SAMHSA

Substance Abuse and Mental Health Services Administration

37TH MEETING
OF THE
SAMHSA NATIONAL ADVISORY COUNCIL

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COUNCIL MEMBERS PRESENT

Charles H. Curie, M.A., A.C.S.W.
Chairperson

James R. ("Duke") Aiona, Jr.
Co-Chair

Daryl Kade, M.A.
Executive Director

Toian Vaughn, M.S.W.
Executive Secretary

Columba Bush
Member

Gwynneth A. E. Dieter
Member

Diane Holder (Telephonically)
Member

Barbara Huff
Member

Thomas A. Kirk, Jr., Ph.D.
Member

Thomas Lewis
Member

Theresa Racicot (Telephonically)
Member

Kenneth D. Stark
Member

Kathleen Sullivan
Member

Beverly Watts Davis

Westley Clark

Kathryn Power

SAN DIEGO, CALIFORNIA - MONDAY, JUNE 27, 2005 - 9:15 A.M.

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CHAIRPERSON CURIE: Good morning everybody and welcome to the 37th meeting of the SAMHSA National Advisory Council. I want to begin to get underway because we have a lot to discuss today. And as you all know, we also have a full afternoon today.

In response to a request from the members of the Council at our last meeting, we have arranged to visit the California Screening Brief Intervention Referral and Treatment Program here in San Diego. I know that Council members have been wanting to see programs first-hand. So this is our first opportunity.

I might mention that our good friends and colleagues, Theresa Racicot and Diane Holder, are joining us telephonically this morning. I think they're adjusting the connection right now to help take care of some of the interference.

Can you hear us, Theresa? Hello?

(No response.)

CHAIRPERSON CURIE: Well, maybe we took care of the interference, but we lost our Council members. I'm sure they'll try to regain them in a moment.

I, again, am pleased to see everyone here today. Again, as you can see, our Council members that are here

with us today, first of all, I'd like to recognize Lieutenant Governor Aiona, who was not able to join us in December, but it's wonderful to see Duke here today. I'm also pleased to announce -- as you all know, Pablo Hernandez left the Council, and I've asked Duke if he would be willing to serve as co-chair of the Council, and he graciously agreed.

(Applause.)

CHAIRPERSON CURIE: Again, as you can see, we have Columba Bush with us today, we have Ken Stark, and Gwynneth Dieter, and Kathleen Sullivan. Also, I'd like to highlight that we have -- and I did mention Barbara --

MS. HUFF: That's all right.

CHAIRPERSON CURIE: You're worth mentioning twice, Barbara. And then I'd like to introduce a new member of the Council today, and that's Tom Kirk, who is the director of mental health, as well as substance abuse is under his purview, in the State of Connecticut. I've known Tom for over a decade. He's been a colleague. Connecticut's one of those cutting edge states in terms of operationalizing recovery in a very real way, and as representing really the state mental health program directors, as Ken represents the state drug and alcohol directors, it's just wonderful having you aboard, Tom. I just welcome you here today.

MR. KIRK: It's an honor to be here. Thanks.

CHAIRPERSON CURIE: I want to make an announcement about one of our Council members. Gwynneth, we met you last night. I'm pleased to hear -- I was a little concerned -- I was happy for you -- you might want to share the good news about your husband's appointment. The good news is Gwynneth is going to continue to serve on the Council and continue to attend our meetings. We'd like to share this wonderful news with the Council.

MS. DIETER: My husband has been confirmed as of ten days ago as Ambassador to Belize.

(Applause.)

MS. DIETER: It's a huge honor. We're really excited. And we will move down there. But one of the first things I said is, can I be on SAMHSA still? And so we called, and they said, yes, you can still serve on the Advisory Council. So I'm very happy that I'll be able to do that.

CHAIRPERSON CURIE: Well, that's good news for us and for substance abuse and mental health. So congratulations, Gwynneth. I'm also pleased to hear you'll be able to actively participate and still be attending the meetings. That's great.

As you know, absent from today's meeting is Thomas Lewis. Do we have an update on Thomas, Toian?

MS. VAUGHN: He's still very, very ill.

CHAIRPERSON CURIE: Very ill. So he's unable to attend.

And as you know, Dr. Jane Maxwell, who's just been a phenomenal Council member through the years, her term expired, and we're in the process of preparing a nomination package for the current vacancy.

I also would like to recognize some individuals today who are here as guests. One individual that I would like to recognize is Kathryn Jett. Kathryn is the State Drug and Alcohol Director for California, and just does a phenomenal job out here. Again, we're blessed with some very strong people in our field, in substance abuse and in mental health around the country. I'd just like to ask Kathryn if you'd like to say a few words.

MS. JETT: Well, thank you very much, Mr. Curie, and thank you all for selecting California for your meeting today. I hope some of you got to enjoy the fireworks last night. I got to my room just at the precise time where -- about ten o'clock -- when the fireworks started. So if you're staying this evening, and you didn't have a chance to see the fireworks last night, enjoy it this time.

We're pleased that you're here. You picked one of our gem cities to meet in. So I hope you'll enjoy San Diego while you're here. On behalf of Dr. Naberg, Director of our state mental health organization -- thank you -- he's

the Director of our State Mental Health Department -- and he's running around the state. We each inherited a proposition. I inherited Proposition 36, and interestingly enough, he inherited Proposition 36 (sic), and so they just inverted the numbers -- 63 -- sorry -- 63 and 36. So he is running around the state dealing with the many complications to come about when you get this type of an initiative. But it's, I think, a welcome addition to the mental health area for the state, as was 36 to the drug area. We're in the process of debating the reauthorization. Proposition 36 actually expires next year. But one of the key components of that proposition was that the funding is the only part that expires. The proposition stays on the books. So if we -- actually, if we fail to fund it -- guess what -- we would've probably legalized drugs in California, wouldn't we? So this is a very interesting debate that we're moving towards this year.

Other areas that I think are important in California that we're focusing on that may be of interest to you is, again, Dr. Naberg and I are very much engaged in addressing co-occurring disorders from the vantage point of having two separate departments in this state provide leadership. We find that both of our hands are very full. So we sort of take each other's back, as I am trying to do for him today in greeting you.

The other areas that we're focusing on are methamphetamine. We'll be talking with both -- certainly Dr. Clark and Beverly about, because it's certainly -- it's -- California, unfortunately, has a lot of data in this area. With Proposition 36, over 50 percent of the people that come in are meth addicts. Of those, the highest proportion of meth-addicted people are women, and they're women of child-bearing age. So this is something that's of great concern to us. We're also seeing a spike in seeing that Asian Pacific Islanders are becoming -- females -- are the largest user group in California of methamphetamine, and Hispanics are also growing. It's something that we're working with public health very closely with trying to get at the potential epidemics that surround that particular drug use.

Then lastly is what I mentioned, the reauthorization of Proposition 36, where we have about four different laws running through the legislature this year. The signals are very good that we will be able to amend the law. I think we're going to base the amendments of the law on research. This will probably be challenged in the courts. But I think with having the kind of data that we have behind us, I am optimistic and hopeful that we will see Proposition 36 look more like drug courts that have more accountability. I think that, plus what we need for the funding, will put

us in good stead in California, and hopefully we'll be able to share that with the nation.

Thank you.

CHAIRPERSON CURIE: Thank you so much. Thank you, Kathryn.

I'd also like to recognize two individuals from sister federal agencies, Dr. Craig Vanderwagon, who's the Medical Director for Indian Health Services. We are doing our meeting jointly with the Indian Health Service in conjunction with our behavioral health conference here in San Diego. We've worked very closely with Craig in a variety of settings. I just appreciate Dr. Vanderwagon's partnership. Thank you for being here today.

I'd also like to recognize Beth Bowers, who's here representing the National Institute for Mental Health on behalf of Dr. Richard Nakamora and Dr. Tom Ensel. We also have -- I'm pleased -- the three senator directors for SAMHSA here today. I'd like to now turn it over to the co-chair, Duke Aiona, for a few words and an opportunity for people to introduce themselves.

MR. AIONA: Thank you. I did graciously accept this position a couple days ago.

(Pause.)

Aloha to you. First of all, I'd just like to say thank you for this opportunity. I did miss the meeting in

December. But a lot has been done in the State of Hawaii also. Before we go around, maybe we just can share -- when we go around, if we can just share something that we've done in our states, or as Dr. Hernandez said, ambassadors of SAMHSA.

So for me, the biggest -- I wouldn't say the biggest, but one of the big things that we did was the teach-ins -- Reach Out -- Reach Out Now. I did that a couple years ago when they first came out. We did one school, and then last year I did about three or four schools on my own. This year what I did was I said, I want to make it a little bigger, and let's try to see if we can kind of put it on the scale of Read Across America. I don't know if you know about that program, Read Across America. They get as many people as they can and try to cover every school in the state. At least in Hawaii that's what they do. They try to cover every school in the state with somebody reading to the second, third, fourth graders.

I wanted to do that with the teach-ins. We did pretty good. We got over 30 celebrities who were like coaches. We only have one big university in the State of Hawaii. It's the University of Hawaii. So I got all of the coaches from football, basketball, volleyball, and got all of them involved, got some of the local media personalities involved, newscasters, radio personalities. Got this one

big local comedian, who's really big with the kids, and got him to do it also. It was real successful.

What I did was I put together a PowerPoint presentation, and kind of -- if you want to -- let them use if they wanted to. But they were so good at it, they didn't use it. They did it on their own. I just gave 'em the material, and I said, Here's the curriculum. You can look at it. Make sure you hit a couple of points, and you do whatever you want in the classrooms. But just make sure you engage the students in what you're trying to get across. And they did, and it was very successful.

The other thing that we did was we got together three of our local celebrities, who did very well nationally. You might've heard of 'em -- Brian Clay, who won -- who was the silver medalist for the decathlon, Jasmine Trias, who was on American Idol last year and was a third runner up, and a surfer who lost her arm to a shark, Bethany Hamilton. We had three of them do anti-drug, anti-alcohol ads for us, and we put it all together, and I'm putting a tape together now so I can go back and show it to the fifth graders, who are now going to be in the sixth grade, and see what kind of impact we had on that.

So next year I think we can cover almost every school in the state, which would be about 270 schools. We're going to try to make that really a big thing. So I'm

kind of proud of that. I'm proud that we're mobilizing right now. We have underage drinking as our big target right now. Hopefully we made some great strides, and we'll continue to do that.

So why don't we just go around the room right now, and I'll start to my right, and we'll go with Columba first.

MS. BUSH: Thank you. Good morning.

I've been working in drug prevention for many years now. When my husband became governor, then he thought to have an office for drug control. We've been very blessed to have Jim McDonough as a director. He's been very, very successful because of -- he takes care of the office, and he has put all the organizations together. We have two summits a year. Every year we have more and more and more participation.

What I do is travel through the state and to other states, visit schools, go to conferences. I think we have a lot of wonderful support. Whenever we put action into our words, I think that is what has worked for us, and also to have a director, because he is focused in that. And so my husband and I, we just participate. We just try to do our best, and I'm just very, very proud to serve for SAMHSA.

So thank you.

MR. AIONA: Thank you, Columba.

Ken.

CHAIRPERSON CURIE: We're going to introduce -- just go around the table, and you can introduce yourself. Kathryn Power, our wonderful, competent Director of the Center for Mental Health Services, who's leading our mental health transformation.

MS. POWER: Thank you very much. Good morning everyone. It's wonderful to be here. It's a great opportunity for us to actually do two things, because the Indian Health Services is meeting over across the way, so we were able to say hello and good morning to all the substance abuse treatment specialists from Native American and Alaskan Natives this morning. So Beverly and Westley and I were there. So I'm going to have an opportunity to speak with you and talk with you a little bit on a presentation at 11 o'clock. So I welcome that opportunity, and thank you all for being here.

MR. STARK: Ken Stark, State of Washington, single state agency director for alcohol/drugs. One of the things that's fascinating for me is we've done a lot of research in Washington State, and that over the years, we've worked really, really hard to try to reduce stigma and to try to increase services in both prevention and treatment. It has been a long, hard struggle. But we've been fortunate enough this last year to get the legislature to give us a 50 percent increase in our state funds. It represents a 30

percent increase in our overall budget. That's about $67 million new money for the biennium. But with that comes a great deal of expectations to continue to prove cost offsets.

One of the things I want to thank SAMHSA for is having the SBIRT grant, the ATR grant, as well as SPF SIG. Those three federal grants will go a long way in helping us provide a full continuum of services to folks in Washington State. So we thank you for that.

CHAIRPERSON CURIE: Thank you, Ken.

MS. DIETER: I'm Gwynneth Dieter from Boulder, Colorado. I've just continued being involved in the Boulder Effort, which is a parent engagement network, and then Compass House, and haven't done as much the last few months, but -- because I was busy doing other -- but they have made tremendous strides, actually. I'm just so proud of all the people who have worked harder than I have, because we've met with the school district. Finally it's accepted as a force -- Back to School Week -- Back to School will include in high schools now talks, information for parents on substance abuse and mental health. There are going to be workshops all during the year. This network -- people get information on the network. So if a parent just even has a concern what's happening -- I just found something in my child's backpack -- they can just call one of these people

and start talking to them.

Then we have -- and the Compass House, which is organized by a psychologist who had been a counselor -- there are 50 -- or -- I'm not exactly sure of the exact number -- psychiatrists and psychologists who have volunteered their time. They assess the students and families who come in, and then they see them in various capacities at a reduced rate. And now they're giving classes, and now they're considering having a residential program, because at the same time, we've been getting funding and support from businesses and people within the town, which -- so, finally, after years, it's like this huge sort of community effort coming together, and a recognition that -- you know, what the problem is, and mostly trying to also, you know, educate parents as to the dangers and what to look for and so forth. So I'm very proud of their work in particular.

Thank you.

MR. CLARK: I want to thank Charlie for having this meeting here in California. Although this is my fourth time here in California in the past month. I visited Tom Kirk and Ken Stark here in the past month. We've been actively addressing the issue of ATR and SBIRT. We're going to be visiting -- this Council is going to be visiting one of our SBIRT grantees, Kathy Jett, this afternoon.

I've been actively outreaching the faith community as a part of our ATR efforts involving a wide range of groups, such as Teens Challenge, making sure that it's clear that the faith community is a part of our recovery management services and feels welcome to participate in the access to recovery initiative.

We're getting ready for our September Recovery Month. I want to encourage the Council members to keep that in mind, because September is Recovery Month.

Thank you.

MS. SULLIVAN: My name is Kathleen Sullivan. I have been on the -- as well as Barbara Huff -- have been on the Planning Committee for the upcoming IHS SAMHSA Behavioral Conference. Both of us have made sure, as everyone has on this Behavioral Conference, that the needs of the American Indian community in addressing the high rates of suicide, as we have addressed within this advisory board, are reflected in the agenda of the upcoming conference within its plenary sessions and also some of its work groups. We hope that some of the agenda items that we have had here in this Advisory Council will be reflected in the upcoming conference.

Also, over the past couple months I've been working with Mark Weber and other people, other consultants, in the upcoming Voice Awards, which will be held in a month,

which will award -- and it's going to be held in Los Angeles at the Skirball Center, which is somewhat put on with SAMHSA -- correct? -- yes -- which will award the Hollywood community, producers, stars, people who have portrayed -- given a favorable view of those who have done well -- or how should I say it? -- have given a favorable light to those who have overcome mental illness, a favorable light in conquering stigma. We hope that this will -- it's the first -- first time this has been done in Los Angeles. I think Charlie will probably talk more about this. Mark Weber is very, very happy with the way this is coming together. It should be a very, very successful event. We'll tell you more about it in December.

MS. WATTS DAVIS: Well, good morning. It's a pleasure to be here.

I just wanted to just share with you, one of the things of being at this conference has been a very, very nicely and much needed conference. I am pleased to report to you all, we will be having a meeting between both the tribal leaders and the state and the national prevention and the state prevention directors to figure out how we can do a much better job of integrating many of the tribal issues within the whole state planning system. So I'm looking forward to that meeting. I am really pleased to report that we actually have our first Native American program that has

actually been an in-rep., and they're represented here today -- Mr. McClellan Hall -- I've known him for 15 years. His program with the National Indian Youth Indian Leadership Project is in our in-rep., and we are now supporting the second program called Walking in Beauty. That's very important, because the tribal customs and practices, the way that they -- they have a different way of measuring things. So we're going to be working with them to come up with measurements -- culture-competent measurements to be able to really look at how they're affected in their community. So I'm really pleased and excited about that. And that will just expand upon what we're all about.

MR. KIRK: I'm Tom Kirk. I'm the Commissioner of Mental Health and Addictions for the State of Connecticut. I am honored to be at this first meeting, at least for me, for the Council.

A couple of things that we're particularly proud of -- when I began my term about May 2000, whenever it was, I made a very -- some very significant decisions, at least in my part, I think. One was that the agency that I oversee we describe as a health care agency. Why would we do that? Chances are everybody in this room has a card in the back of their pocket, purse, whatever, that's their health care card. What that health care card implies, at least to me anyway, is that when I go to my health care provider, I

should get better -- not necessarily be cured of whatever my illness is, but I'm going to get better. Furthermore, the person who holds that card has the choice of health care providers.

So consistent with the emphasis on the health care agency, we then moved on and said recovery would be the driving force behind our whole service system. In Connecticut, we treat about 60 to 80,000 people a year for mental health and substance abuse issues, and on the prevention side, a much larger group of people.

The idea for me behind recovery is really two things. One of them is that anybody who comes into our system for care should expect that, as a result of that interaction, they will learn the tools to help them manage their illness or their symptoms. And secondly, as Charlie Curie has continually pointed out, what is equally, if not more important, is that once managing their illness, they will go on to have the highest qualify of life that they could possibly achieve.

As a psychologist, I will say I feel guilty about the fact that for too many years within our system, coming into an agency such as mine was viewed as a lifetime journey; that once you come into the mental health or substance abuse agency, you would be in there for the rest of your life. Treatment, to me, is a point in time.

Recovery is a lifetime journey.

A couple months ago in Connecticut we had one of the breast cancer walks, and I participated in it. The persons who were survivors of breast cancer, they wore certain things on their head. It was a different color. When you think about that, people who are recovering from mental illness, people who are recovering from substance abuse issues, would it not be something to see that we would have a walk similar to that, and people would proudly run and walk such as that, and not be ashamed of who and what they are in their illness.

And so one final piece that ties back to this. Where I grew up, it was very, very common that if someone in the neighborhood was ill, you'd send 'em over a casserole -- or if they were in a hospital. When was the last time you have heard anybody in any neighborhood where a person went to a substance abuse treatment center or a mental health treatment center, and someone sent over a casserole to that particular family? That's the kind of stigma that we're trying to overcome.

So what I'm particularly pleased at, the Access to Recovery Award, the Strategic Prevention Framework, all of these are based upon what I call a wellness or a health approach. So as long as I've been in this field -- and I mentioned it to Charlie last night -- I think this is the

most exciting period of change. But sometimes it's scary. It's quite a challenge. So I hope that forums such as this will help us to continue to push the agenda, because thousands of people's lives depend upon what we do, and what you do at SAMHSA.

Thank you much.

CHAIRPERSON CURIE: Duke, I might mentioned that Theresa and Diane just joined us again.

Can you hear us, Diane and Theresa?

MS. RACICOT (Telephonically): Yes.

CHAIRPERSON CURIE: We want to make it clear, they did not leave us, we left them. I think the technical difficulties have been overcome at this point. So welcome back. Duke is now chairing the meeting. We're going around --

MR. AIONA: We've been going around the room. So we'll go to Barbara, and then we can go to the phones.

MS. HUFF: Hi, Theresa and Diane. We miss you here.

MS. RACICOT (Telephonically): Well, we miss you, too. I bet you're having a wonderful visit.

MS. HUFF: It is really nice. Yes. Thanks.

I'm Barbara Huff. I'm formerly the Director of the Federation of Families for Children's Mental Health in the Washington, DC area. I'm a parent, and I say that

because I really believe that I represent families on this Council. I just want to say how proud I am to sit next to you, Tom, who just said all that about breast cancer, because I have a daughter with breast cancer. I've said for a long time that we need to figure out how we got to the place where breast cancer can be talked about at anyone's dinner table.

Anyway, I loved it that you said it, because it now means that I can kind of lean back and not have to say it all the time. So -- and I have other people that are fan clubs of those kinds of messages.

I just want to say that -- as most of you know, I kind of semi-retired and moved out to Kansas in October. So I'm working part-time with Vanguard Communications and systems of care, and working with families and service providers on how to create a message in their community about systems of care and about children's mental health in the broader perspective, as well. Then, of course, when I came back to Kansas, I couldn't help but get totally immersed in everything that's happening in Kansas. I didn't mean to, but I did. I do love Kansas. I have to say it's been really neat.

Jane Adams, who is Commissioner on the New Freedom Commission, runs our statewide family organization. Immediately she said, Barbara, would you want to run some

focus groups for us across the State of Kansas on some of the goals of the New Freedom Commission? And the one we picked first was family and consumer-driven services. So I ran focus groups with consumers and family members and children, younger kids and older kids, transition age youngsters, young people, and older people, to see if we could take the definition that the federation was asked to come up with, to define what that really meant, what "family-driven" meant. The Center for Mental Health Service, Carrie Blough, and the Child Adolescent Family Branch asked the federation to define it. And we did. We had a lot of focus groups, and that was going on when I was still there. So we took the definition, and went around in Kansas, and got total buy-in in Kansas from NOMI (ph), from the older adults organization, from -- and like I said, from families who had three to five-year-olds, and families who'd been dealing with substance abuse problems. So we got total buy-in about what that meant with that definition. We were really proud of that.

What we didn't do as well as we should've is to have gotten the professionals in the service provider community and the mental health center directors -- we didn't get the same buy-in. So we're still working on that.

So anyway, I -- so that's kind of what I've been doing. But I also got back from Hartford -- and loved

Connecticut, and that was a neat experience. So I've been going to some of the regional meeting on system of care. So that's been really fun, too. So I'm semi-retired, kind of. That's all I can say. I'm not really.

MR. AIONA: Thank you, Barbara.

Diane, why don't we go to you first. We're just kind of introducing ourselves and just giving a little bit -- just a little about what's been happening.

MS. HOLDER (Telephonically): My name is Diane Holder. I am the President of the University of Pittsburgh Medical Center's Insurance Services Division. Essentially what that is is it's a group of insurance health management companies that manage benefits for people who are either covered by commercial insurance, Medicaid or Medicare. As part of that umbrella of insurance companies, we also have a company called Community Care Behavioral Health, which manages benefits for approximately, at this point, over 600,000 individuals. But many of those individuals are part of the Medicaid program. And so many of them have persistent severe mental illness, as well as other physical health needs.

My background prior to managing and running the insurance companies was I spent about 20 years fairly exclusively in the field of behavioral health, where I was the head of Western Psychiatric Institute and Clinic, which

is a large academic medical center teaching hospitals for psychiatric residents, and had a large clinical service. And so that I have always had a great deal of interest in helping develop clinical service programs for folks with psychiatric or substance abuse problems.

Then the newest part of my life is really transitioning into, how do you help finance services and programs so that people can recover and get the kind of services they need for a price that the people who are buying those services can afford to pay? So that's a little bit about me.

MR. AIONA: Thank you.

Theresa, good morning.

MS. RACICOT (Telephonically): Hi, Duke. How are you?

MR. AIONA: I'm doing good.

MS. RACICOT (Telephonically): I'm sorry not to be in California with you again.

MR. AIONA: That's all right.

MS. RACICOT (Telephonically): I'm Theresa Racicot, and I'm actually a displaced Montanan to Washington, DC. I tell people I'm retired, but I don't know if that's really true, because I don't seem to be idle. I'm a volunteer, basically. I spend a lot of my time working on the Leadership to Keep Children Alcohol-Free, the Spouses'

Initiative, addressing childhood drinking in America. We recently formed our own foundation, and I'm actually the President right now, I think because I reside in DC. I'm very interested in mental health, have been for years. I worked on it a lot when I was in Montana, and Charlie was kind enough to invite me to join the Council. So I'm delighted to be a part of it and to be working on getting rid of stigma and making life better for people who suffer with mental illness.

MR. AIONA: Thank you, Theresa.

MS. KADE: I'm Daryl Kade. I'm the Director of Policy, Planning and Budget. I've been busy working on the '05, '06 and '07 budgets. Mr. Curie will be talking about that later on.

MS. VAUGHN: I think everyone knows me. I'm Toian Vaughn, and I'm your Executive Secretary.

MR. AIONA: And she's also indispensable.

One more item before we go back to Charlie. We have the minutes of the December 7th and 8th, 2004 meeting. We need to approve these minutes. I guess I need --

MR. STARK: Correction. If we could go to page 11, page 11 under the Council round table discussion, if we could delete the second paragraph, Medicaid no longer provides monetary backup for programs, that needs to be deleted. Then if we go down to the last sentence in that

paragraph, the next to the last line where it says, "Reduction in opioid drugs being disbursed or dispensed at treatment," cross out the word "treatment." It should say "hospital emergency rooms."

MR. AIONA: Where was this at again? I'm sorry, what paragraph?

MR. STARK: The next to the last line in the first paragraph, where it says, "Reduction in the opioid."

MR. AIONA: And the change again?

MR. STARK: The change again is the next to the last line in that first paragraph, where it says, "Reduction in the opioid drugs being dispensed at" -- and then it says "treatment." Cross out "treatment" and replace it with "hospital emergency room" -- or "rooms" -- and that's it.

MR. AIONA: Any further comment on -- or how about comment on just these changes, anybody object to it?

(No responses.)

MR. AIONA: No objection. Any other comments?

(No responses.)

MR. AIONA: Can I get a motion to approve these minutes?

MR. STARK: So moved.

MR. AIONA: Second?

MS. DIETER: (Raises hand.)

MR. AIONA: All in favor.

(Hands raised.)

MR. AIONA: Thank you. All opposed.

(No responses.)

MR. AIONA: There being none, it'll be accepted.

CHAIRPERSON CURIE: Before I begin my report and then move to the budget discussion, I also want to recognize some other individuals that are with us today -- John DeMirand (ph) is with us today from the National Association of Alcohol, Drugs and Disabilities. Welcome. Donna Demetrich (ph), who is -- I knew from my Pennsylvania days. She's now with the Johnson Institute, works with Johnny Allen with the Johnson Institute. Welcome, and thank you for being here today.

I'd like to invite anyone else in the audience that we have not recognized who might want to -- okay -- if we've covered -- Steve Sawmelle is here from SAMHSA working with -- he is our tribal liaison, and obviously has worked with this conference that we're participating in. I also want to recognize Mark Weber, our Director of Communications. And I'm still speaking to Gail Hutchings, even though I have to let you know today that she's going to be leaving SAMHSA. She is quite ably and just in the most competent way has served as the Chief of Staff at SAMHSA. Although I will miss her, and her contributions have been extremely valuable as you take a look at everything from the

conference in New York City after the 9/11 attacks, the substance abuse and mental health planning conference bringing states together within a matter of -- that was, what, three days? -- I think you pulled it toge- -- oh, three weeks -- that -- what a lot of folks said it takes nine months to plan a national conference, and it was planned and wonderfully executed -- to all the work on the Mental Health Commission and everything she's contributed in terms of that action agenda -- and also I take -- just being engaged with all three centers and the work of SAMHSA, I think people have always found her to be an extremely competent advisor in helping us guide the agenda in a very, very effective way. Substance abuse and mental health is further along because of her efforts. We'll miss you, Gail, but thank you.

(Applause.)

CHAIRPERSON CURIE: To talk a little bit about the conference, we're preparing for and tending to the last-minute details for this large national conference, which begins here in San Diego -- actually tomorrow officially begins. San Diego was chosen as the location because it, again, coincides with this conference -- over 500 federal, state and tribal government leaders, along with medical and mental health providers and substance abuse prevention and treatment providers will participate in this three-day

conference. Also, this has an international aspect to it. We have international guests from New Zealand, Mexico, Canada and Australia. So again, I know some of you are planning on attending. I think if you're able to, I think you'll find it very worthwhile, and I encourage everyone's participation in this conference.

I also understand that Kathryn Jett, of course, will be a participant and participating, so it's great.

Again, in addition to the conference tomorrow, we've also been reaching out -- as I mentioned, the international scene -- continuing our efforts working with many international partners, just to update you in some of our efforts there, including the Iraqi Ministry of Health. As an emerging democracy, Iraq has begun making decisions related to public health. We've been working with -- SAMHSA's been working through HHS with the Iraqi Health Ministry in the development of their new mental health and substance abuse plans.

One piece of progress I want to mention is substance abuse is now clearly in the planning process. Initially they reached out on mental health. Initially they weren't necessarily identifying that they had any substance abuse problem. Now they are saying, yes, we do. And the great news is it's a very good public health approach.

Since we met last, SAMHSA organized and sponsored

an action planning conference for Iraq -- mental health -- that was held in Amman, Jordan in March. The conference brought together Iraqis, along with more than 20 American and British experts who served as information resources. Since then, we also attended -- in fact, Gail accompanied me to London -- and the West Kent Trust in London hosted the Iraqi professionals for a period of several weeks for training in community-based services. We were able to work with them in the conference there.

Also through the International Initiative for Mental Health Leadership and other organized activities, SAMHSA's gaining strong international partnerships, which bring opportunities for learning and sharing information I think we otherwise wouldn't have. What's I think exciting -- and Kathryn's been participating very actively in helping us lead in the International Initiative for Mental Health Leadership -- is the fact that recovery -- and, Tom, I appreciate so much your remarks earlier -- recovery has developed to an international focus in terms of people understanding that we're looking to manage illnesses and manage life and looking at those outcomes. Clearly we must remain committed, I think, to nurturing these partnerships, and in doing so, demonstrate that we are a compassion nation that's continuing to reach out.

I also want to thank all of the Advisory Council

members, our ex-officio members, our state and federal partners present today, as well as the representatives of the constituent groups for the tremendous work you do. Just listening to you share at this table today -- and I've noticed going out and meeting with constituents when I speak with Kathryn, Wes, or Beverly, as they are doing their work across the nation -- when you hear people articulating more common themes -- and recovery is one, resilience is another that people are talking about, and people are focused on the same outcomes -- you're hearing the outcomes discussion occurring to where -- I think at one time when you had a discussion of outcomes five years ago, ten years ago, there was a lot of disparity in that discussion -- what we should be measuring. We're seeing, I think, a consensus emerge, if you will, which I think is going to move us forward.

Then listening to all of your activities today, the difference that could be made at the local level as these efforts are translated, really I think we have a lot of true partners in helping realize that vision of a life in the community and building resilience and facilitating recovery. I'm pleased to say, individually and collectively, each member of our Council I believe brings a valuable resource to SAMHSA. Again, we'll have an opportunity to talk more about our efforts.

When we met in December, we had a chance to review

our progress and to begin to examine what still needs to be done. We also began to map out our future plans during our President's second term and the direction of the new Secretary. One other development since we last met, we do have a new Secretary of Health and Human Services, Michael Leavitt. Secretary Leavitt has issued his 500-day plan, which, if you haven't seen a copy of that, we want to make sure you all have that available to you. I think you all should've received a copy of that.

What I find very exciting about the plan, and in my discussions with the Secretary and his Chief of Staff, Rich McKeown, is the alignment we have. When you hear Kathryn talk later about mental health transformation, the alignment between that transformation agenda and how it's aligned with overall health care transformation, which is a major priority for the Secretary, health information technology is a major priority, Medicare -- implementation of the Medicare Act and transformation of Medicare, top priority -- Medicaid, top priority -- as well as pandemic flu. In most of those priority areas, we very much have a lot of activity foundation laid from the first term that we're going to continue to build upon the second term, and have alignment. So it's very exciting to see that.

Again, when Tom said we are probably at the most exciting time perhaps ever in the behavioral health field in

terms of the federal, state, local partnerships, and public and private partnerships that can occur, seeing this alignment with Secretary Leavitt's leadership is extremely exciting and gratifying.

One other change I might mention, too, at SAMHSA that I didn't note earlier, we do have a new Acting Deputy Administrator since we last met, Andy Knapp. Many of you knew Andy. He was Deputy Chief of Staff for Secretary Thompson, and actually handled the portfolio which SAMHSA was included for Secretary Thompson. So he's been a strong advocate for SAMHSA, and a very able manager. He's holding the fort back in Rockville today. So I wanted to make that announcement.

Going back to our meeting in December, I shared with you that our plans, both immediate and long-term, would need to incorporate a focus on increasing efficiencies, taking a look at outcomes, pushing science, and pushing science into service in a more efficient way, containing health care costs while increasing access to services, and operationalizing -- again -- recovery from a public policy and public finance perspective. Again, just as I share those things, you can tell they're daunting and challenging tasks.

But much has taken shape since our last meeting. The six core goals of the Secretary's plan that I mentioned

earlier, one, transform the health care system and modernize Medicare and Medicaid, advance medical research, secure the homeland, protect life, family and human dignity, and improve the human condition around the world. I think when you think of those points, everything that we've been mentioning in terms of different activities in which we're focused on relate to each one of those areas, and we have a role in each.

In particular, we'll need to be prepared to ensure a smooth transition for people with serious mental illness and addictive disorders when the Medicare Modernization Act is implemented on January 1. This is something that we are keenly focused on. We are working with CMS, the Centers for Medicare and Medicaid, and also through the states. The partnership with the states will be critical during this period of time to help consumers understand how and when to pick a prescription drug plan that can best suit their needs.

As of January 1st, persons who have both Medicaid and Medicare, or that are called dual-eligibles, will pay for medications through the new Medicare benefit under the Medicare Modernization Act. In the United States, there are approximately seven million people who are in that category of dual eligible. Just under half of these people have some form of cognitive impairment or issues around mental illness

or mental disability. In Part -- Medicare Part D, the prescription drug benefit, CMS has put into place several regulatory provisions that are designed to assure each Medicare beneficiary will have access to the medications they need. We know this is particularly true for people with mental illnesses. We will continue to work closely with CMS to manage the changes the act sets forth, and will continue to work with our partners to make the transition as smooth as possible. We want to make sure this is done right. CMHS is engaged very directly with this. Anita Everett is the point person out at the Office of the Administrator who's working with CMS and leading our efforts. The Secretary has engaged every operating division in making it very clear that each of us are expected to have a role in this, and recognizing each of us have our own constituency groups that are impacted by this.

We've also sent a letter out to the state mental health and drug and alcohol directors asking each authority to appoint a point person in the state that we can continue to work with and help states roll out plans for reach-out. Because the states are going to be a critical partner in this process.

We've accomplished many needed changes over the past few years, and have dug deep, I think, to building a new foundation that -- again, a goal I think we all have --

because I talk a lot about myself being a temporary steward. Clearly, I think Council members are in the same boat. You're term-limited. So we are temporary stewards in this position.

I think the good news is the progress we're making will bring about changes, and are bringing about changes that will outlast us. The key is when we leave that we have confidence that recovery is secured in terms of influencing public policy, that resilience is understood, that outcomes are going to be clear, and that we have more confidence we're going to measure them and paint a picture -- the type of picture Ken paints in Washington State we can paint for the whole nation. I think it would be just incredible.

I think one of the tools we've used that's helped us is the SAMHSA matrix. The matrix, along with our vision and mission, will continue to be our guide. The matrix is aligned, again, with Secretary Leavitt's priorities. So the great news is we have no need to start from scratch. All the work and investment that we've put into the progress so far can continue. But I think there's going to need -- there's a great need to have -- keep a close eye on what we define as priorities and to make changes in the matrix as the needs change and as the data tells us.

Again, you've heard me talk about redwoods. That's what we're about doing is planting some solid

redwoods that are going to stay and be around. If we grow the redwoods, they'll continue to make solid, lasting improvements.

If we focus on our core set of priorities and accomplish them right away, then I think we'll see what we need to be doing in terms of fulfilling our responsibilities. For example, what we're doing in substance abuse prevention and treatment is a cornerstone of what is being done to stop the spread of HIV/AIDS. We're pleased to say that we have over 213,000 rapid testing kits that are across this country. We've never had that capacity before, and we've been working in partnership with state public health authorities, substance abuse authorities, to get those kits in the hands of providers where people will appear who could be at risk of HIV/AIDS so that they can find out.

CDC -- and this points out an important partnership, that we at SAMHSA always need to be partnering with CDC, with our other agencies, operating divisions, fellow operating divisions within HHS. CDC came out saying that they believe there's up to one million people in this country that are HIV-positive and don't know it. We know that the population we serve is in the highest risk categories when it comes to substance abuse, when it comes to mental illness. So we need to step forward, assume

responsibility, and see what we can do to try and bring that number down, and so people will know whether they are or not, and then can take the appropriate action. And also it's a prevention effort, as well, that we need to be focused on.

What we're doing in mental health system transformation is what needs to be done to better serve those that are homeless or that are in the criminal justice system, and that all of our efforts combined better serve children and families. That's a major focus of the matrix, and we need to be thinking about how all these efforts are continuing to press that forward.

This approach is a strategic approach. We have a President with a strong management agenda with expectations. We have efforts that must be aligned with our department and must be in step with performance measurement and management requirements. And that's an ongoing goal that we have.

SAMHSA's now operating more than ever before in a performance-based, outcomes-based environment. We have to -- and I think all of us can agree want to -- provide services which bring about real outcomes for real people, outcomes that measure recovery and resilience. The matrix, along with our data strategy, is doing just that. We've made considerable progress in the development and

implementation of a SAMHSA data strategy. Our goal is to achieve a performance environment with true accountability.

We've looked at the data that we're collecting. We've asked, why are we collecting it? And we've asked, how are we using it to manage and measure our performance? If we found we're not using it, we choose to lose it, and really put our efforts in what really is measuring what we intend to see in terms of outcomes. So our emphasis is on a limited number of national outcomes related to these outcome measures. They're built on a history of extensive dialogue with our colleagues in the state mental health and substance abuse authorities, and most importantly, from feedback from people in recovery, from consumers, from families, from parents.

The domains we've identified, again, embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, to work, learn, live and participate fully in their communities. Again, those domains -- I think you've received a listing of those. They include abstinence. They include when we talk about a job, a home, and connectedness to others. We are going to be measuring those types of things in these domains. We're going to be measuring whether people have access to what they need as they attain recovery, whether they are sticking to their recovery plan, and is the

recovery plan working for them? Also, are they involved in the criminal justice system, or have less involvement in the criminal justice system?

I want to give a lot of credit to both NASHBUD (ph) and NASIDAT (ph), because, again, they've been the critical partners for over a decade trying to come to some sort of clarity on what type of national outcome measures we need. And we've attained that with both of those organizations due to the leadership of those organizations, sitting down and taking a look and, I think, listening on the part of all parties in terms of also what's doable, what are developmental measures. You know, we haven't fully arrived yet on those measures, but we have to have an open dialogue and process to move it ahead. I'm pleased to say I think we've made more progress probably in the last six months than we did in the previous nine years in terms of reaching that level. I know Ken and Tom have some thoughts on that, as well, so when there's a chance to share about this -- but it's profound -- when we pull this off -- and we will, and we are -- it'll be profound in terms of putting us in a position to be able to describe to all Americans, members of Congress, people in OMB, how our dollars are helping people achieve those meaningful outcomes, and people understand that outside of our fields -- and that's the other thing that's a critical part of what we need to be

doing.

The other thing that I want to mention that we're working hard to do at the national outcomes is again assuring that those are the domains that we're measuring in everything that we do -- our block grants, the discretionary grant portfolios in all three of our centers -- and that will help give us a comprehensive picture.

While we're aligning ourselves around national outcomes, it's also important for us to think about those things that -- and we have a long-term view -- those things that may emerge in an urgent or crisis-oriented way. SAMHSA needs to remain nimble and responsive to the needs of particular consumer groups to emerging trends, and also to unpredictable or catastrophic events. As examples, we'll continue our efforts to make older adults aware of the dangers involved with inappropriate use of prescription medications. We'll continue our suicide prevention efforts focused on our nation's youth. And we'll continue to fund our targeted capacity expansion grant programs to address emerging needs in states and communities across the country, emerging drug use needs as we might be identifying them in different parts of the country.

We will provide assistance when tragedy strikes, like the Florida hurricanes, for example, this past year, which I know one of our Council members is all too familiar

with the devastation that occurred last year with that.

In fact, later this morning after we discuss the budget status and resume from our break, as I mentioned earlier, Kathryn Power, Director of our Center for Mental Health Services, will provide greater detail on SAMHSA's response to the recent tragedy at Red Lake. Again, our partnership with IHS has been critical in that process. We were all shocked and saddened by the recent onset of violence among the Red Lake Band of Chippewa Indians in Minnesota. We responded and was able to make available $73,000 in emergency response grant to continue mental health and substance abuse services to help combat the widespread psychological consequences for those who live, who go to school, and who work on the Red Lake Reservation. Again, building resilience and facilitating recovery is a common thread among each of these activities.

As I mentioned earlier, those priorities are mentioned in our matrix, and I just want to highlight a few others as part of my report -- aspects of the matrix. Access to Recovery -- increasing substance abuse treatment capacity -- and we're doing that through Access to Recovery. It was designed to expand treatment capacity by increasing the number and types of providers, including faith-based providers, who deliver clinical services as well as recovery support services. Again, the ATR program is based on

consumer choice, using a voucher. It allows consumers in need of treatment to use their voucher to find and purchase the best services for them. In this way, recovery can be pursued in that very personal, individualized way, which recovery is all about. As we talk about operationalizing recovery, it clearly -- Access to Recovery is one way we're striving to do that in a very concrete manner.

We have funded 15 grantees, 14 states, and one tribal organization. There's a solid chance this coming fiscal year, if we continue to rally, we still may get an additional $50 million. I think all of us here, I assume, are disappointed to see the House mark kept Access to Recovery at really a level funding. What's good to hear, at least from states like Washington and Connecticut, who have Access to Recovery, that you're going to continue your funding. But it was disappointing to see we can't expand that to other states because of the interest, of course, with 66 -- also California's an ATR -- gosh, we have three ATR states represented, and with the First Lady of Florida, we have a lot of ATR states represented here. But again, we need to do what we can to see that we're able to expand treatment capacity, because we know the gap -- the treatment gap is great in this country. Hopefully we'll fare better in the Senate mark. The good news is we're not finished yet. So hopefully there can continue to be support for the

President's budget.

Along with dealing with both the issues around recovery, stigma's been mentioned this morning by several individuals. I think it's critical for us to be thinking in terms of how to address this, because it is a barrier on both the substance abuse and mental health side. In particular, when we look at mental health systems transformation, finding help for people with mental illness is equally as important. Not knowing where to go for treatment is the first roadblock for many people seeking help. We have to do more to take the mystery out of where to go for help.

The objective has to be getting in the groundwater of our society. The notion of -- and I like Tom's visual depiction of the day that perhaps we overcame stigma with diseases such as breast cancer and cancer in general, and people speak with pride about being survivors now -- that we're able to bring mental illness and we're able to bring addictive disease out in the open, and people can talk about where they're at in their own recovery. We're trying to take a fresh approach to combating stigma. The anti-stigma messages that we've been sending out for decades, while have made some progress, I think we would all agree we have a long way to go to make a definitive impact on American society.

We need to craft a message that's effective, the message that mental illness is an illness like any other, and help is available, and that treatment works, and that recovery is real, that addictive diseases, as well, is an illness like any others that can be treated. We're looking to find new audiences and different audiences to hear from us and learn from us. One such opportunity just occurred. I participated in the United States Conference of Mayors. I had a chance to talk to mayors about issues around mental illness, their desire to open up opportunities for people to find treatment in their communities, being able to work with their criminal justice systems and address it as a public health as well as a public safety issue, and do it in a non-stigmatizing way.

I had a very good discussion with Mayor Daly about the issue of recovery in Chicago, with the conference being held in Chicago. I think there's some partnerships we can develop. I know Kathryn's been working with the National Governors Association, as well, reaching out there and talking with the upcoming issues around mental health transformation.

We've conceptualized recovery. We now need to articulate it in ways that more local governments and the public can understand it. There are 19.6 million people with mental illness in this country, 22 million people with

a serious substance abuse problem. First and foremost, we need to -- and again, keep in mind that they're people with lives to get on with. Thankfully, today we know more than ever before. So again, a lot of the work we need to be doing is doing what we know -- doing what we know and implementing what we know. I think that's the awesome responsibility of SAMHSA as a services administration.

I'm pleased to say that this week we're going through some final briefings within the Department, and I'm very hopeful that the action agenda, which, again, has been Kathryn's primary -- one of her primary -- definitely her top priority as she's come aboard to help shape -- with 20 federal agencies. It includes other departments besides HHS, as well as pretty much all the operating divisions within HHS, to have an aligned agenda. I'll be meeting with the Secretary this week. We'll be briefing him on the action agenda.

The great news is we haven't waited for the release of the agenda before we've started our work. Again, the transformation -- state incentive grants that are out there to help states have the resources they need to have an alignment -- an aligned agenda at the state level have been approved, and we're implementing those. We're well underway with suicide prevention efforts. What the action agenda will do for us, it'll show the whole picture of what a

transformed system can begin to look like. And it's really the federal action plan in terms of the first federal steps for the federal government to demonstrate leadership and commitment to mental health transformation. Again, we'll be hearing more from Kathryn about the transformation efforts.

Strategic prevention framework. And again, what I'm really pleased with with the three center directors here, each one of these three directors have awesome responsibilities and are very much key leaders in moving the agenda ahead for SAMHSA. For Beverly and CSAP, the strategic prevention framework -- which, again, the other thing I might note, all three centers are working on all three of these initiatives together, as well. While one center may be the lead center, the collaboration that's occurring is at a level, I think, unparalleled before within SAMHSA.

But our strategic prevention framework, I explained at the last meeting the concept of the framework. Fortunately, word about what works in prevention I think is getting out more and more, the notion that each community will have a plan within those states to get an SPF, a plan in which they will understand what prevention dollars they have available to them, that they will be able to identify the risk factors in their community, the protective factors, and then invest their money in programs that we know that

work to address those risk factors.

Of course, one thing I'd like to highlight when it comes to strategic prevention framework is the whole issue that we must address underage drinking in that process. While we made progress in teen youths and other areas, and we're at 17 percent decreased illicit drug use among teens, compared to over three years ago 600,000 fewer teens are using illicit drugs than they were in 2001, we are seeing underage drinking rates remain stubbornly the same, and binge and heavy drinking in some areas actually going up. Again, we have our work cut out for us.

The original legislation for SPF highlighted that we expect underage drinking to be addressed in each of those grants. I've always said, show me a community that doesn't have an issue with underage drinking. I want to visit it, find out what they're doing, because we can learn from that, because it's really the most pervasive substance being abused.

We also need to be pressing and working toward an overall strategy. And I'm pleased to say that the Interagency Council, which SAMHSA chairs for the Department, is going to be submitting its final report to Congress by the end of this summer. For the first time, we will have a federal strategy, again with alignment of federal agencies to address underage drinking and to bring this to the

forefront. And it's a multi-faceted effort. We must address this at many levels. And again, Theresa mentioned the First Spouses Initiative. They're a very critical group in pressing this agenda. The Reach Out Now efforts that Duke mentioned -- and I know that many of you participated in in your own areas -- are all a part of, how do we begin to get parents to talk to children about the issue?

We also are working with the Ad Council, and we're hopeful now that we've been able to find the funding. The good news is we had funding for one PSA. Between SAMHSA and the National Highway Safety Transportation Administration, we've been able to come up with dollars to fund another one. There was a little bit of a shortfall in the Congressional Act. I heard it was an honest mistake that was made. But we were able to find dollars for this and be able to have two PSAs. A lot of it is trying to get to the day that underage drinking is really viewed as something that has to be stopped, and that it isn't just kind of viewed with a wink and a nod, unfortunately, in our society. And again, we know more than ever before, and I think we'll be held accountable for that.

Again, in our Reach Out Now efforts, we're excited that next year -- it expands every year -- and I know with efforts being put forth by the first ladies -- and I know -- well, Duke, you participated directly; Columba, you

participated directly; and I know Theresa did -- it just makes an impact. Kids bring the piece of paper home with them to take to their parents to say, Talk to me about this. That's really critical and important.

I just want to conclude by saying that SAMHSA will continue to do our part to build upon the matrix priority, to develop and be guided by our strategic plan, which you know was circulated for public comment, and it's also been posted on our website, and it's now to be revised, cleared and published before the end of the fiscal year. And most importantly, we'll continue to put consumers and families at the center of care for them to drive care and move ahead.

So thank you. And now I'd like to open it up for any discussion, comments, thoughts from Council members.

Ken.

MR. STARK: You know, it's always been fascinating to me, as we talked about stigma, thinking back on the history of the field of addictions, as well as mental illness, that in our zeal to separate ourselves and create a distinction, we created these terms like "behavioral health," and that that became a very common term. I believe that in our zeal to create that distinction, we've actually done a disservice to our consumers, that the term in and of itself, "behavioral health," does differentiate us from health. People then don't see us as a health problem, they

see us as a behavior problem. That in and of itself negates the physiologic, biologic and genetic basis for mental illness, as well as addictions, and focuses simply on the behavior.

I think that we need to get away from that. I think if we're truly going to be a health field and remove stigma, we need to get away from the term "behavioral health." That's a mantra that I've been singing for a long time, and I'm going to keep singing it, that our stigma will not go away as long as people think these are nothing but behavior problems.

CHAIRPERSON CURIE: Thank you, Ken.

MR. KIRK: Medicare Part D, when are the vendors selected, the ones who would operate the plans?

CHAIRPERSON CURIE: When are they selected?

MR. KIRK: Yeah.

CHAIRPERSON CURIE: We can get that information of any time frame. I think they're in the process right now.

MR. MARK WEBER (Speaking from Audience): So much of it's coming together right now. We're actually working with CMS to get information out on the specific vendors to the states, to the people who will be making the choices.

CHAIRPERSON CURIE: So we'll get -- and that's information that we're going to have to every point person in the state in terms of the timing of that.

Barbara.

MS. HUFF: Do other countries have the same problems with underage drinking? I mean, is this worldwide an issue?

CHAIRPERSON CURIE: I think it varies from nation to nation. But I think it is something that is more pervasive internationally. It depends really on the society and the tolerance for alcohol and its use.

MS. HUFF: Okay.

MR. AIONA: We brought this up at the leadership conference meeting last month about in Europe, I believe, they have a lower drinking age of 18 in some countries. They were supposed to be the model of alcohol and how it affected our young people. It's been devastating. I think the data will show that it's really a big problem in the European countries in what it's led to. A lot of people don't believe that it's a gateway to other drug use and problems in the community. So I know there's a lot of data out there. I don't know exactly where we can get that, but I know there's a lot of data. We had a big discussion on that.

If I can just kind of move -- you know, it was after the last meeting in June -- last June meeting that we had -- and there was a packet on terminology that was sent out to the members. I guess I got one. What's the status

of that at this point?

CHAIRPERSON CURIE: Mark?

MR. WEBER: We started out with the treatment packet, and as we went around and people -- it became more where we need something similar for prevention, as well as mental illness, and there was actually a series -- I saw it last week -- a series that three guys were putting together -- that we're going to be using that. So it's getting close.

MR. AIONA: So it's being finalized?

MR. WEBER: Uh-huh. Absolutely. It's created -- it's another one of those things that's created a lot of internal conversation, too, about which word to use, and how to use it, and -- and so --

CHAIRPERSON CURIE: Be careful what we say about "behavioral health," Mark.

MR. WEBER: And the word "screening" doesn't exist. But anyway, so it's created quite a discussion, but it's still moving along.

MR. STARK: I would hope it comes back here as a draft before it goes out as a --

CHAIRPERSON CURIE: Absolutely. One comment I want to make about the behavioral health observation -- and I think Ken makes a very good point. I know it's pressed at time what you name a state authority. I think substance

abuse and mental health services administration, I think that gives clarity in terms of what we're about. I know that I've been personally resistant to any public entity begin to be named "behavioral health" because the term hasn't been well-defined at times.

MR. AIONA: I'm just saying that the terminology discussion kind of plays onto what Ken just stated. I found that to be very interesting. And I circulated it amongst our providers. It did create a lot of discussion. So ...

CHAIRPERSON CURIE: Any other comments from Council members?

(No responses.)

CHAIRPERSON CURIE: I also might mention, in the report to Congress on underage drinking, you're going to -- that's going to be a multi-faceted approach, comprehensive, the role the other federal agencies are playing, an inventory of what's being done coordinating it, plus the role of a national summit that we're looking to have in the fall, and participation by the Secretary and the Surgeon General, as well as there's serious consideration being given of how the Surgeon General could have a call to action with addressing underage drinking specifically. So I think there's going to be a lot of opportunity to bring this awareness to the forefront.

Diane, Theresa, is there anything you'd like to

share? Since you're not here, if you raise your hand, we can't see you.

UNIDENTIFIABLE FEMALE VOICE (Telephonically): You're not calling on us today?

CHAIRPERSON CURIE: We're asking you -- yeah, we're assuming maybe you raised your hand, so we want to ask you, is there anything you'd like to add?

(No responses.)

CHAIRPERSON CURIE: Okay. Let's now move into a discussion -- our next item is discussion on SAMHSA budget priorities. Do you recall -- this is something that has been discussed here at the Council. I know several members have indicated that they want to make sure that they have an opportunity for input. We want to elicit your input around our budget, as we're in the development, as we're looking at '07. And '06, now, of course you know, is being considered before Congress.

I think some things to think about -- I'm going to be turning this over to Daryl to facilitate it, since she is my key ELT lead on budgetary matters and developing the budget -- in examining what we are -- I guess I can put -- what -- what we're up against is a time in which there's a real contraction as we take a look at trying to move ahead, if you look at the '06 budget compared to '05, it's a rather pervasive perception right now, both within the Executive

Branch and the Legislative Branch, both are struggling with finding the dollars to fund all the needs that need to be funded and addressed. So much of what we're trying to do is prioritize -- how to leverage dollars better, where do we want to put dollars for priorities? And again, I would say the matrix has come in even handier during the more austere budget times than when the budget times were a little better.

That said, I think as we take a look at resources, we have an opportunity to reallocate resources as we examine what we have around priorities, leverage resources, and I don't think we should hesitate during budget development to also think about, if we are able to garner new dollars, where would we want to put our efforts to think about asking for new dollars in this type of environment?

So those are the types of, I think, elements we need to keep in mind as we think about input to the budget process. And I'd like to now turn it over to Daryl.

MS. KADE: Thank you. What I am going to do is briefly go over the President's budget, some of the principles that we used for '06, and then briefly review the House mark, and then hand it back to Charlie to go through a discussion in terms of future budget directions and some funding scenarios.

My material is in Section F. Toian, is this the

same section in their briefing books, Section F?

MS. VAUGHN: Yes.

MS. KADE: Great. And what I wanted to point out in Subsection 1 is the standard -- what we call the APT table, which is the all-purpose table. What you have here is a lining out of '05 enacted, the '06 President's budget, which has been on the Hill since February. We now have the House mark. The deltas, the changes that we look at, are changes relative to the President's budget, and also relative to our current enacted level.

I then wanted to take you to Subsection 2, which are budget accomplishments and a synopsis of the '06 President's budget, not organized by our APT table, which is by budget line, but organized by our matrix areas. In presenting the budget on the Hill, we have presented it in both ways, in the traditional budget line way, as well as the matrix way. Then I wanted to point out that we even have a table that we publish in our budget that presents the funding by matrix area.

I wanted to point out some of the principles we used for the '06 President's budget. I can answer questions about it, but it's been on the Hill for so long, I wanted to at least share the principles, because these are principles that we take with us as we go into an analysis of the House mark and the Senate mark, and then as we bring forward our

recommendations to the Secretary and OMB as we go forward into '07.

Clearly what Charlie said is our guiding principle, which is everything is referenced back to the matrix. In addition, within the matrix, we grow our four redwoods as much as possible -- major big redwoods. You can see the focus in our '05 enacted level, and our '06 President's budget in terms of the increases overall in terms of our overall level of funding, as well as reallocations to ATR within CSAT and SBF within CSAP, the mental health transformation grants within mental health, and co-occurring, which is jointly funded by CSAT and CMHS.

We have a balancing act between the discretionary grant programs, as well as the block grant programs. We have consistently supported the block grant programs as we've been growing the larger redwoods with new funds, as well as reallocated funds. Then as you go through our budget, within the discretionary grant portfolio, we have two sets of programs. We have capacity expansion programs, which focus on infrastructure development and services, and we have best practices programs, which focus on the identification and scaling up of best practices and service-to-science, science-to-service activity.

You can see in the President's budget, especially with a restricted amount of money, you can see the

maintenance of the block grant programs and a shifting between best practices and capacity expansion. Primarily the cuts that we see are in best practices, primarily the investments, either additional resources or reallocations or in-services. And we're constantly trying to balance that act. These are principles that we deal with all the time.

Another principle that we dealt with in the President's budget, regardless of the fiscal climate, we try to avoid cutting any continuations. To the extent that we need to stop programs, we wait for the natural expiration of the program to avoid problems in the field. That is our first priority, and we try and do everything we can to avoid those contingencies. We have to make very hard choices between grant programs and contract programs in order to make sure that our grant programs are not terminated before they are completed.

So these are the principles that we take with us as we not only develop a budget recommendation, but as we see it through as it goes through various phases on the Hill, as we develop impact statements, and as we prepare for the '07 budget.

I now wanted to take you to Subsection 3. Here is really the latest and greatest information that we have. It is on the House mark. Here I'm going to talk in a little bit more detail to give you the latest update. We obviously

don't have the Senate mark, but they will be working on it when they get back from recess.

I'll point out the table above, which is a summary of our House action. Although we have an overall cut of 37 million below the '05 enacted level, we have an increase of 16 million above the President's budget. But the story is very mixed as we go through all of our centers -- CMHS, 43 million above the President's budget; CSAP, 10 million above the President's budget; CSAT, 37 million below the President's budget.

What I wanted to do is go over the highlights of each of the centers. For CMHS, again, it's 43 million above the President's budget. As you can see through the highlights, we have significant activity in the PRNS line. The SIG grants have been funded as requested at $26 million. School violence, a best practices program, has been restored. The National Child Traumatic Stress Initiative has come in as requested. The big question in CMHS, as funds are restored, counting up those funds, and making sure that we have enough funds to allocate among the various directives, and seeing what else is left and the extent to which we have flexibility.

And you'll look at the other line. CMHS has the most budget lines. Everything else, the Mental Health Block Grant, the Children's Mental Health Program, homeless and

PNA are basically straight-lined.

As we move to CSAT, again, 12.9 million below what we currently have, and 37 million below what was requested. Obviously, the big item here is Access to Recovery funded at the same amount as last year, which means, again, as Mr. Curie had mentioned, we're still working on an additional $50 million with the Senate. We'll see what happens there.

Screening, Brief Intervention, Referral and Treatment, we got what we had requested.

In the PRNS portfolio for CSAT, I think the big question is, as we go through internally our analysis of the House mark is, what sort of flexibility do we have to grow the ATR budget with the amount of funds and the direction we have from the House? And I think a lot of it will depend upon what we get from the Senate in terms of dollars, as well as direction, direction to do things, and directions not to do things.

Finally, CSAP has a decrease below the '05 level, but significantly, a $10 million increase above the '06 level. Here you have sort of the opposite situation of CSAT. Here, with the increase for $10 million, the question is, how will those funds be used? -- since, unlike the CMHS situation, you don't have a description or particular directives, how to best use those funds consistent with the administration, consistent with the support on the Hill, and

consistent with our own priorities within the matrix. Here, especially in CSAP, you have that interesting balance between best practices and capacity expansion. How do we develop the correct balance for us?

The reason why I'm going through this is not only to give you a highlight of the House action, but the very same logic model that we would use to do the internal analysis of the House action and to look at the Senate action would be the very same framework that we would use as we approach the '07 budget, and how to apply those principles in various funding scenarios.

Yes?

MR. STARK: Daryl, what's the -- on the very bottom of that page in 3, on the very bottom of the chart up above, where it says, "Less public health service eval. funds," where does that money go?

MS. KADE: The PHS evaluation funds, the Department has the authority to tap various programs for PHS evaluation activities. Most of our budget is tapped but for the block grants -- all of the NIH budget, a lot of the optives. Then those funds are programmed. We receive a lot of the PHS evaluation funds as an offset to fund the set-aside portion of both block grants. Plus we get additional funds that are directed to our program management line. In the past, about two million was used to help finance a new

data activity for CMHS. But also in the past, and continuing, is a certain amount of money used to offset the household survey.

So the PHS evaluation funds is like a tap against HHS. Once the funds are appropriated to the various optives, they are then tapped and redirected. Most of them are redirected by Congress. And so you can see that in our report language.

MR. STARK: We call that a "whine list" in Washington State -- a w-h-i-n-e --

MS. KADE: Yes, yes. That certainly plays into the dynamics -- dynamics not only for the Hill, but also especially when we're dealing with very restricted budget scenarios, look in all sources of funding, and not just direct approps, but reallocations and taps becomes an interesting dynamic.

CHAIRPERSON CURIE: Do you have -- first of all, any questions? Ken led off with some questions. Again, I want to stress that what we try to do in looking at the '07 budget, and before we get explicit direction from the HHS Budget Office, we try to think in terms of how we are going to approach our budget if we're given direction that there's going to be reduction of a certain amount. How are we going to approach it if it's a level budget? And how do we approach it if we get an opportunity to have a little bit of

an increase? We never think of a lot of increase, because we just -- we may try to make the case, but again, we try to go in with the best case possible to prioritize to show we've done our homework, to really be as responsible as possible, but yet still communicate clearly our commitment to the overall vision and overall priorities.

So keeping those three things in mind, as you take a look at some -- the -- the priority areas, as you take a look overall, and also just as Council members, as you bring to this table your thoughts about what's important, your thoughts as you look at this, and lay out some things you want to make sure we're considering in that budget process, I welcome that.

Also, I want to say that, while this discussion today is going to be rather short compared to the assignment of input, after today's meeting, we want to encourage you as Council members to bring forth your thoughts back. Today is primarily to have this initial discussion around budget.

I almost might mention, as guidance in terms of what Daryl's used, we have made -- tried to make very careful choices. And when we do look at reductions, or we're told that we need to reduce, as we look at this, we look at areas where grants are coming to a natural conclusion so that we're not cutting grants in midstream. And so those entities that know their grants are concluding

would not be depending on or expecting any other dollars. We try to mitigate it as much as we can as we move ahead.

At the same time, I think we need to be thinking of new and clearer ways to help grantees with sustainability if we begin to see that a grant's doing very well. That's where our partnerships with Medicaid can be real critical. Our partnerships with the states can be real critical -- criminal justice, other type of entities, as well. So we're always looking as to -- and we're really trying to encourage grantees from the first day they're awarded a grant to begin thinking about how they will sustain the effort -- if it's a successful effort, how they will sustain it after the three or five-year cycle ends.

So with some of those thoughts in mind, Barbara?

MS. HUFF: Of course, I immediately go first to children and families, and then I look at the rest.

CHAIRPERSON CURIE: I would expect nothing less from you.

MS. HUFF: Kathryn's going to do something here shortly for us around Red Lake, and yet I look at this School Violence Prevention reduction of 27.4 million, no new grants or contracts. I guess I struggle with that, because is it like are we thinking we don't have that problem anymore? I mean, do we just -- you know, we have a crisis, and we start funding things, and then, oh, we got a natural

end to Partnerships for Youth Transition, and it's not really my favorite program, so I'm not going to sit here -- I'm not going to probably advocate for that with you right now -- but, however -- it's not -- they don't do any family involvement at all -- but anyway, I think that, you know, it seems to me like I just would like to know how you make a decision like that and use balance.

CHAIRPERSON CURIE: I think it's an excellent question. I really would like to answer that. Because the disadvantage -- I mean, there's an advantage of listing these by matrix priorities. But the disadvantage is, when you have something like that, on the surface it looks like, are we backing away from our commitment to children and families?

MS. HUFF: Right.

CHAIRPERSON CURIE: That's primarily in the Safe Schools/Healthy Student area. It's not in kind of the traditional systems of care or other areas.

MS. HUFF: Right.

CHAIRPERSON CURIE: What we're looking at, a couple things go into that decision. One, as of yet, we don't have data that tells us how effective those dollars are going to be. So when you don't have the data in this environment, and you have the tough decisions to make, you begin to take a look at, what can we defend with data? And

those programs that have a strong parts score based on the OMB evaluation process, or we have great outcome data that tells us, here's what we're achieving, puts us in a stronger position to advocate.

Safe Schools/Healthy Students, those dollars are used in a variety of ways.

MS. HUFF: They are, yeah.

CHAIRPERSON CURIE: They're out there with school systems. They're used in different ways. We're trying to determine, what are the effective models that are bringing about a true reduction in school violence? And we're going to have, hopefully, our first round of data this fall. And so as I shared with our subcommittee -- appropriations committee -- is if we see that the data is pointing us to programs that are really working, that puts us in a position to take a look at '07 and future budgets for restoration or for some further growth.

Also, as we look -- and we'll be talking more about Red Lake -- we also need to sort out, where can the dollars be best used? For example, when you look at the Red Lake tragedy, how much of that is a general school violence issue? How much of that is because of the challenges facing Indian country? And there can be some differentiation with that.

So, clearly, Barbara, you're right. We need to

keep this as a priority. We need to keep looking at it. But that's what's behind some of these decisions. It's not saying these aren't important areas. It's saying, in the context of this budget, what do we want to focus on?

One other point I'd make, too, is the danger with the matrix area and having a matrix out there is you want to see increases every year. And I'm pleased to say, the first term, we were seeing increases every year in our matrix areas overall. And again, the budgets were easier budgets during that period of time. We always should be keeping in mind that we're going to see increases some years in the matrix areas, and decreases in the matrix areas as we move along -- just the nature of the budget. But as long as we state it as a matrix area, we're keeping it out there as a priority so we don't forget it, and we keep accountability around all of us. Just as our discussion now is keeping the accountability around children and family. So I appreciate your efforts.

MS. HUFF: Thank you.

MS. POWER: Charlie, I'll just add that I know the concern has certainly prompted us to begin to take a look across the SPF initiative with substance abuse prevention and connecting the community efforts in substance abuse prevention with the educational departments and the school systems so that we can build the bridges. Even if some of

those grants don't continue, we will build those bridges with some of the Safe Schools/Healthy Students initiatives that can be tied into the SPF, and that we can tie into some of the mental health transformation. So we're working very hard to make sure that that goes on.

CHAIRPERSON CURIE: Wes.

MR. CLARK: Yeah. A good example of this experience is I was just presenting on methamphetamine in Tucson, Arizona. As part of my presentation, I was reviewing SAMHSA's portfolio going into Arizona. I polled the audience, and most of them didn't know that Arizona had an SPF SIG, didn't know about the mental health grants, didn't know about the community coalitions. They had about four or five community coalitions.

So I realized that (speaking unintelligibly fast) been getting together CSAP and CSAT among staff to have a state grant round where everybody discusses what is going on in the states from the block grant level to the specific discretionary programs. And it's clear that at the SAMHSA level, this kind of effort in terms of communicating with project officers about what's going on in jurisdictions helps the message get out to the states about what's going on in jurisdictions getting multiple grants that are not leveraged because things are fragmented. I think our effort is to make sure that we coordinate things based on the

matrix will allow us to use both the block grant and the discretionary portfolio, involving the single state authorities both in the substance abuse (speaking unintelligibly fast) authorities so the money is well-spent.

CHAIRPERSON CURIE: These are moments that excite me greatly, because I'm hearing from two key leaders, from Kathryn and Wes, how their operationalizing matrix management and leveraging of resources and thinking in new ways. The SPF connect between CMHS and CSAP is, again, profound in terms of, how do we leverage the resources? I think it also points out the challenge of using our matrix, too. We've had discussions -- what -- what -- we're -- if you -- if you add up the matrix totals, it adds up to our budget. It's an unduplicated count. But in essence, there are things in the mental health transformation, for example, that really relate to children and families that aren't reflected in that line. SPF -- a lot of things we're doing in SPF, that's children and family and mental health-oriented, that's reflected in the SPF line, but not in the children and families line.

So we've talked about how we can really get a full reflection of that. So that's the other thing is leveraging is critical and important. Collaboration is critical and important. A systemic approach is critical and important. And yet the matrix would keep it an unduplicated count of

dollars, if you will, in terms of how it's reflected.

So --

MS. HUFF: Can I just say one more thing?

CHAIRPERSON CURIE: Yes, Barbara.

MS. HUFF: There's kind of more than one way to skin a cat, so to speak. I'd be all right about eliminating this, because I'm not -- or not new grants. I'm not always thrilled with how people spend their money out in the field. And I'm not sure that I like the idea of just spending it on someplace that's spending that money on security. Okay?

But this is what I do know. We know a whole lot now about bullying. The stuff you sent out in the mail, Toian, about bullying, I gave that to my daughter, who runs a preschool program, and she's started a curriculum with three-year-olds on bullying. Okay. Now, we could do something with that bullying stuff that you've got that I think is really good stuff.

MS. POWER: It is. It's wonderful.

MS. HUFF: It relates right back to violence prevention, in my opinion, --

MS. POWER: Right.

MS. HUFF: -- because of everything we know about all these shootings and stuff around bullying. Now, so maybe we could think differently about the use of some of those dollars, but not give up on the notion -- I don't know

what that says about us if we're not interested in school violence prevention. But we know there's a lot of good stuff out there. I'm not sure it's getting all to the right people all the time and stuff. But I was wondering if we could just look at a different way of dealing with school violence prevention. I mean, if we could just say to ourselves, this is really important, you know, and --

MS. POWER: Barbara, it's key, and we do care about it. We're thinking about ways that we can take particularly the bullying program and replicate it even further, even beyond the life of it, and working with Mark's shop and making sure that we get those materials replicated, and think out a distribution and dissemination plan even beyond the life of that.

MS. HUFF: Yeah. Okay. Okay.

CHAIRPERSON CURIE: Kathleen.

MS. SULLIVAN: On the subject of bullying, if we're going to --

MS. HUFF: I'm sorry. I didn't mean to get us off --

MS. SULLIVAN: I'm sorry. I think I've made myself clear in the last agenda. I mean, I see this as a Department of Education problem, as something in the teaching area. But I don't understand how it links into mental health and substance abuse, et cetera. I mean, I see

this as something that is a local teaching -- something that's within school districts and school superintendents. I don't see the link here to mental health/substance abuse. It is a fabulous, it is an important issue -- no question. I don't see it within the realm of our purview.

Our resources are very thin. It's an important issue, but I can't see where -- if -- if we take our resources and go into this, I think we're getting out of our purview.

From the teachers that I've talked to, this is something -- this bullying issue is something that's very local. It's wonderful to have these pamphlets, et cetera, but maybe this is something that should be distributed by the Department of Education. When we have a chance, I want to continue on something.

MS. POWER: Well, and I think we do have a partnership with the Departments of Education. We think it is a local effort that has to happen. We've simply been able to provide, I think, appropriate materials, Kathleen, in terms of being able to give this program and replicate it and disseminate it out so that it's a tool. And I think it is appropriate, because we've found that the mental health status of children, and their readiness to learn, and their readiness to be in an educational environment is affected by their emotional state. And obviously their emotional state

is dramatically affected by the presence of bullying.

We actually got requests for information about, how do we address that? And that's how we developed the program. Once the program is developed, though, those resources get out to the local practitioners, to the schools, to the teachers, to the parents, and it just gives them the tools to take ownership of it themselves. So we believe that the ownership should be at that local level.

CHAIRPERSON CURIE: Beverly, go ahead.

MS. WATTS DAVIS: I'll make mine very quick.

One of the things that I wanted to emphasize about the Strategic Prevention Framework, that it happens at both the state and local level, Florida is the best example of when it works, and when it works right, how effective it can be. And then we don't have the discussion of, is school violence a mental health or not a ment- -- because what that does is it really is about looking at what's happening across your risk and protective factors in a community. And what you're going to find is there's going to be crossover. And when you begin to focus and target on addressing those risk and protective factors, you will address all of those issues.

What's very key about the framework is that it is about doing what Wes has talked about, where you've got the state looking at all of their funds, and instead of defining

themselves by their grant source, they begin to look at the risk factors, and take all those fundings, and begin to fund it toward their problems. That is the new way of doing things, and we will find the leveraging that we need across the board.

CHAIRPERSON CURIE: Tom.

MR. KIRK: New person on the block. Let me ask a question. I don't know whether this is in accord with the Council's activities or not. But when you go before Congress, Charlie, what seems to resonate with them? What is it they sort of focus upon? That, and secondly, this group as a Council, how can we be supportive or more helpful to you as you go -- the co-chair of the Appropriations Committee in Connecticut, I mean, you get up before him, and he says, can you tell me, Commissioner, is the situation the same, better or worse? He doesn't want a five-hour conversation about this piece. When you go before them, what are the things that seem to stand out the most, so that we in our role can somehow be supportive of moving the agenda that we're talking about?

CHAIRPERSON CURIE: That's a great question. I think one general answer I'll give to that is it's interesting that if you take a look at the members of the subcommittee, there's a level where each one has their own issue, depending on their passion. For example, Congressman

Kennedy is passionate about mental health, mental illness, co-occurring disorder, children and youth and older adults, and hones in right on those matrix areas that he has a real interest in. You can pretty well, each one of those individuals, predict -- Congresswoman Ro (ph) Ballard is very much focused on underage drinking, and is really a leader in that area and arena. So one level is knowing what each one's priorities are.

I think a general type of thing that works -- and Chairman Regula (ph) is very much focused on outcome, and Chairman Regula would ask not only is it good, better or the same; he would say, how is it impacting my folks locally back in my district? And that is kind of a common theme you hear from all of them. I would say it goes back to -- one common thread, again, would be the outcome focus. That's why the real focus on being able to tell them in a succinct sort of way, we're making progress in kids succeeding in school, you know, who have serious emotional disturbance. We're making progress in that there are less kids getting involved in the juvenile justice system. More adults who come out of prison, the recidivism rate's going down as more people are entering substance abuse treatment -- and we could show that link, and if we begin to paint that picture, that will go a long way. So I would say helping educate and support the notion of the outcome area would be real

critical.

Then any time they can understand how our dollars are being used locally -- what impact is it really making locally in their area? And that picture -- and each of you come from a Congressional district, and each of you have colleagues from different districts -- that's a powerful message for them to see.

One way you can help, as well -- I think it helped tremendously when some of us went to Ohio, where Chairman Regula and First Lady Hope Taft did a Reach Out Now right in his home district. We all did that. If the members of this Council would look at Reach Out Now and some other activities, and engage local members of Congress to heighten the awareness, and they can actually see the dollars in action, that would be extremely helpful.

So, now, clearly there's ethical issues in the sense that Council members cannot lobby Congress. But certainly in terms of heightening awareness of what's happening in the district, you can, you know, in terms of educating or in participating in a Reach Out Now program. And we can give guidance on that, as well.

I think each of you come with a different role. Again, working with your associations -- NASHBUD, NASIDAT, providers associations, the First Spouses Initiatives -- all of that, the groups you represent, can be extremely helpful.

MS. SULLIVAN: Toian, I'll make it quick. I think we're over. Just a couple things. Senator Grant, the special funding, does that come out of SAMHSA?

CHAIRPERSON CURIE: Which one?

MS. SULLIVAN: Senator grant's funding, the suicide funding.

MS. POWER: Senator Smith.

MS. SULLIVAN: Oh, Senator Smith. I'm sorry. Senator Smith -- grant funding.

CHAIRPERSON CURIE: That's primarily in SAMHSA, yes.

MS. SULLIVAN: It is SAMHSA?

CHAIRPERSON CURIE: CMHS.

MS. SULLIVAN: And is that given a special designation?

MS. POWER: It's called the Garrett Lee Smith Act, Kathleen.

MS. SULLIVAN: And is that always funded -- I mean, do the senators and do the House people always know that that's kind of separate and designated as such?

MS. POWER: It is designated in the law. There are two sets of grants, one to the states, and one to colleges and universities. It has been appropriated in the law this year. So we will be enacting that. The grant solicitations went out --

MS. SULLIVAN: Is it always said that way, you know, so the senators and House members always know that it's designated that way within the budget?

MS. KADE: I think you're talking about report language.

MS. SULLIVAN: Yeah, report language. So they always know --

MS. POWER: It is.

MS. KADE: Yes.

MS. SULLIVAN: All right. So it's kind of -- all right.

MS. KADE: And then also in our budget we line it out in a table, and then we identify how much is --

MS. SULLIVAN: Right. Right, right. I was just -- you know, it says one million for the Rapid Testing Initiative. One million?

MS. WATTS DAVIS: That's in addition to what we've already been doing.

MR. CLARK: And that doesn't actually -- you're right, it doesn't include new money for that, so it has to come out of our existing --

MS. SULLIVAN: So what are we spending in total on the Rapid Testing Initiative?

MR. CLARK: What are we spending total on rapid testing?

MR. CLARK: We got 4.8 million before for the first year, and we're in the process of that. What this would do is require an allocation of one million.

CHAIRPERSON CURIE: Yeah. Go ahead.

MS. KADE: There are two sources of funding. We can use direct appropriation, which, this time, we're going to -- at least according to the House, we've been told to use some of our direct appropriation. But the initiative started through the emergency appropriation to DHHS, and we requested and received from them the funding and the authority to go ahead and start the program.

CHAIRPERSON CURIE: So it was departmental money not originally in our budget that was then transferred to SAMHSA to use for that.

Now, another point on HIV test- -- this is a good budget point -- is while we believe strongly in it, and we're putting up some of our own resources, and we've made a commitment, as early testing -- as rapid testing takes off -- and we're going to be following the data in terms of what we're discovering -- over time, this could easily become more of either a CDC overall department initiative --

MS. SULLIVAN: HERSA (ph).

CHAIRPERSON CURIE: -- and HERSA, as well.

MS. SULLIVAN: Don't they have money for this?

MR. CLARK: Well, we actually -- we're in the

process of pulling together the states. There's a set-side requirement under the block grant for some 25 jurisdictions, and they're supposed to do early identification and outreach kind of activities. That amounts to about $58 million. So we've been promoting to the states -- I introduced this notion when I got to the NASIDAT meeting -- that we're encouraging states to use some of their set-aside money for the purchase of tests. Because basically what the CDC's done is changed the whole paradigm for outreach. In the past, outreach had a different kind of character because, of course, there wasn't a whole lot you can do. You lost roughly 30 percent of your people with the two-week testing process. Now with the rapid testing, the states do have the authority to spend some of that money, instead of investing in traditional outreach activity where you lost 30 percent of the people, you can use some of that money to purchase tests, and you've got your people right then and there. I'm fond of saying a cup of coffee and a donut and 30 minutes, and I can tell you whether you're HIV-positive or not. That, I think, is something we also have to think about. But that needs partnering with the states, and we intend to do that.

MS. SULLIVAN: I just find it shocking that this is all in our corner, I mean, that this is not something that CDC is embracing, but with us.

CHAIRPERSON CURIE: What I would say is we provided leadership in this area.

MS. SULLIVAN: Yeah.

CHAIRPERSON CURIE: We do have a high-risk population. It fit well with Secretary Thompson's overall initiative, which included all the operating divisions. This is what we contributed and opened up and --

MS. SULLIVAN: But as a budgetary item, the fact that SAMHSA's carrying this on its back -- and I don't see anything from the CDC --

MR. CLARK: No, no. CDC's got an active portfolio, and HERSA's got an active portfolio. We're working very closely with CDC on this. We're working with the Department on this.

MS. SULLIVAN: But any financial contributions on it?

MR. CLARK: Well, yeah. Everybody's spending --

CHAIRPERSON CURIE: Why don't we pull together a total of what all operating divisions are contributing --

MS. SULLIVAN: Right, for rapid testing. I'd like to see --

(Multiple simultaneous speakers; indiscernible.)

CHAIRPERSON CURIE: -- because everyone is very engaged in this process. Again, rapid HIV testing has been a newer aspect of this. I think clearly it's going to be

part of what all operating divisions are going to be doing.

MS. SULLIVAN: Yeah, because I'd like to see the total money spent on rapid testing.

MR. CLARK: But again, I want to stress we're spending -- we've got a set-aside on a block grant, and it's $58 million, that's supposed to be spent on early identification and outreach. So what we'll do is work with the states so they can identify this. If we only spend ten percent of that set-aside on this activity, which would enhance their outreach activities and make it a lot more performance-oriented, because, again, with the traditional approach of the historical approach, you were not certain what you were getting for your investment. But that was what we had. Now we have tests, and now we can get quantified results. So I think the states will see that it's in their best interests also to use some of these resources for that purpose.

CHAIRPERSON CURIE: I think we have time for one or two more questions. Also, Theresa, Diane, do either of you have any questions or comments?

UNIDENTIFIABLE FEMALE VOICE (Telephonically): Not at this time, I don't, Charlie.

UNIDENTIFIABLE FEMALE VOICE (Telephonically): No. It sounds straightforward. Thanks.

CHAIRPERSON CURIE: Okay. Any --

MS. SULLIVAN: Can I just ask one thing about Access to Recovery? Was the shortfall because they couldn't see an immediate outcome, and that's why the House didn't go for the increased funding is because there wasn't a -- you know, like you just said, that they couldn't have an outcome focus, and that's why they didn't go for the --

CHAIRPERSON CURIE: Well, of course, we made it clear that this is the first year operating ATR. So there was no -- they shouldn't have expected any outcome information. Though the reason you just gave has been an excuse used for that.

MS. DIETER: Why did they -- what was your sense of why they --

CHAIRPERSON CURIE: There's not enough money. There's all these needs, and --

MS. DIETER: So cut something, and because we --

CHAIRPERSON CURIE: -- and they had other priorities they wanted to fund in other areas of the budget. And so that's kind of how it goes in terms of the process. The key for us was we did -- we put a lot of effort into educating and impressing --

MS. SULLIVAN: When will you have a quantitative outcome?

CHAIRPERSON CURIE: Well, the Senate has to come up with their -- come out with their markup.

MS. SULLIVAN: No, I meant of ATR.

CHAIRPERSON CURIE: Oh, when we'll have the outcome measures. Wes, what are we looking for in terms of the initial outcome measures coming out of ATR? I think we're looking -- well, we're starting to get some already. But in terms of anything that would be reportable, I think we're looking toward the middle of the summer.

MS. SULLIVAN: So by 2007's budget.

CHAIRPERSON CURIE: Oh, yeah, we'll definitely have outcome information then. Yeah.

Tom, we have an answer to your question. Plans have submitted formularies already, and these are being analyzed. Once formularies are approved, plans submit cost bids, contracts signed by September 15th, plans begin outreach October 1st.

MR. KIRK: And then one of the critical questions in our state is what medications are going to be covered by the plans? Therefore, in these situations, if I'm on drug-X, medication-X, and X is not on the plan, what am I going to be moved to? Those are the critical pieces for us.

CHAIRPERSON CURIE: Understood.

Any other questions on the budget? One more. Again, I would encourage everybody on the Council, any further questions or thoughts, in light of this discussion, the information you've received, don't hesitate to get

feedback to us as we shape this budget.

Now I believe we're ready for a little bit of a break. Have we heard anything about picking up menus? Toian, housekeeping?

MS. VAUGHN: Okay. One small housekeeping matter. On your -- in front of you is a menu. I'd ask that you make your selections, put your name on it and your room number. We're going to collect them during the break. You'll be dining in the bar area. Once you go over there, you will place your order again. But this will give the catering people an opportunity to know what your selections are, in that the other meetings -- there are about 108 other people that will be converging on the cafeteria around the same time. So this will expedite the meal process. So if you have not completed your form, would you kindly do so, and then turn it in to me to Sandy Stevens or Geri Anderson.

CHAIRPERSON CURIE: So let's take a ten-minute break, and we'll reconvene with Kathryn leading off.

(Recess from 11:17 a.m., until 11:44 a.m.)

CHAIRPERSON CURIE: I'll introduce the Director for our Center for Mental Health Services, Kathryn Power, who will be talking about our response to the Red Lake shootings and suicide, and the efforts of CMHS and SAMHSA in that process.

Kathryn.

MS. POWER: Thank you very much, Charlie, and good afternoon again to everyone. Or good morning still to everyone.

I know Charlie's mentioned on several occasions this morning that transformation is alive and well. I do want to reiterate that I appreciate the support and the attention that this Council has paid to transformation and transformation issues. In many ways, I'm sorry that I'm not going to just talk about transformation today. But I was really heartened when Kathleen talked about the Voice Awards. It's wonderful when I can hear my own agenda coming from some of the Council members. We had a lot of great staff work on the Voice Awards -- Paolo Delvechio from my office and several people -- and we look forward to coming back to California for those awards. But it's really wonderful that -- and Tom, as well, speaking about transformation, and many of you speaking about it.

So I feel like the agenda is yours, and I don't need to spend a lot of time today talking about I think what are the great successes of where we're heading in transformation. But I was asked specifically to talk today about SAMHSA's response to the issues of suicide in Indian country. And so I'm going to take a few minutes to do that today.

There's really two major issues I want to raise

with all of you and leave with you. The first and most important is that SAMHSA is aware of the very great -- and I repeat -- the very great need to improve mental health care and substance abuse care for American Indians. I mean, we are -- truly, truly, our awareness has been building over time, and we are very emphatic about being clear about that great need.

Last March, 16-year-old Jeff Weiss killed nine people before taking his own life. His tragedy and the tragedy of the Red Lake Chippewa community is a reflection of the larger need to improve the mental health and well-being of American Indians nationwide. Suicide is a tragic indicator of the mental health crises among American Indians. It is the second leading cause of death among American Indian youth aged 15 through 24. The suicide rate among this population is 250 times higher than the national average. The problem is more acute in the Upper Midwest, which is the location of the Red Lake and Standing Rock Reservations, and home to the Chippewa and Lakota/Dakota Tribes. American Indian teens in this particular area are ten times more likely to commit suicide.

One of the greatest dangers to teens is cluster suicide, or suicide contagion, in which the death of one person leads others to take their own lives. According to Senator Dorrigan of North Dakota, 288 Indian teenagers

living on the Standing Rock Reservation attempted suicide last year. Ten teens died. Since the March 21st shooting at Red Lake, two more teenagers at Standing Rock Reservation have taken their lives, while several more have attempted suicide.

Two young adults at the Fort Hall Reservation in Portland, Oregon recently committed suicide.

SAMHSA immediately responded to the Red Lake Reservation shootings to help prevent additional suicides and to support a community in crisis. SAMHSA's response to Red Lake was part of a multi-government show of support that drew together federal and state and local agencies, as well as the State of Minnesota and the Chippewa Tribe. SAMHSA promptly provided staffing and resources to the Red Lake Community. Within a week, our staff members were on-site at the reservation, staff members from both CSAT and CMHS. They stayed there for the next month.

Together with the Indian Health Service, as well as other U.S. Department of Health and Human Service agencies, we coordinated a federal response to this tragedy. As other federal agencies arrived to lend aid, this core group was prepared to guide their efforts to where the needs were greatest. These agencies included the Public Health Service Commission Corps, the Administration for Children and Families, and its Administration for American Indians,

and the Office of Minority Health.

Initially, core federal group members referred to their working quarters as the "crisis room." They later changed the name to the "care room." This change is symbolic of the help that we offered, and continue to offer to the tribe. Our initial response addressed the intense trauma and grief that immediately follows a crisis of this dimension. Red Lake is a small and isolated community, so everyone in the community was affected. Everyone was at risk of mental health issues, including the Indian Health Service hospital workers who cared for injured children.

Our subsequent efforts are designed now to help the tribe facilitate the lengthy healing process, and help to prevent long-term trauma among community members.

Before we arrived at the Red Lake Reservation, we had identified SAMHSA grants for which the tribe could apply. Once we were there, we provided technical assistance to help the tribe access emergency funds. We advised the tribal government on how to apply for a SAMHSA emergency response grant, or a SERG. We facilitated efforts by the state government to hire a specialized grant writer. We quickly awarded the tribe, as Charlie mentioned, an immediate SERG grant of $73,000. This particular grant is funding three direct service providers and one support staff member. Counseling and behavioral health outreach is

available to the community at large.

The tribe is incorporating traditional outreach methods in their approach to draw upon the healing powers and strengths of their cultural heritage. Our child trauma program assisted in setting up the counseling services. Also, as Charlie mentioned, we're now reviewing the tribe's application for an intermediate SERG grant which can support services for up to one year.

In addition, our Disaster Technical Assistance Center is working with the Standing Rock community on its own SERG application. In the three years that the SERG program has existed, SAMHSA has given about one third of those grants to American Indian communities.

The first point I made was that we are deeply, deeply concerned, and we are tremendously aware of the mental health needs of Indian country. The second point I want to make and emphasize is that SAMHSA views its response to the mental health needs of American Indians as very long-term and as very broad-based. Jeff Weiss acted out of hopelessness and desperation. He had lost both parents within four years. His father committed suicide, and his mother in a crippling car accident. His future prospects were dismal.

Nearly 40 percent of Red Lake Reservation citizens live below the poverty line. A third of its teenagers are

not in school, they are not working, and they are not looking for work. An internet quote attributed to Jeff exposes enormous mental anguish. In his own words, he said, "The kind of pain that makes you physically sick at times makes you so depressed you can't function, makes you so sad and overwhelmed with grief." According to a state survey of public school students, 43 percent of boys and 82 percent of girls at Red Lake have thought about killing themselves.

SAMHSA takes seriously the mental health challenges that confront American Indians. American Indian communities have extremely high levels of unemployment and multi-generational poverty. These environmental factors contribute to depression and to violence, and can lead to substance abuse. For American Indians, as well as Alaskan Natives, depression and substance abuse are the common risk factors for completed suicides.

Improving mental health services for American Indians presents several challenges. A major challenge is that we simply do not know enough about the differing cultures among tribes. Some tribal communities do not speak of death or suicide at all. We had two women from the Standing Rock Reservation come into CMHS the other day and speak to us, and said, you have to understand that in our culture, when we speak it, we believe that it will happen. Therefore, we can't speak it.

We must design prevention and treatment programs that respect cultural and spiritual beliefs and affirm the unique strengths of individual tribes. This is how we can make programs more effective, by making them more consumer-focused on the cultures that need it.

Other challenges to improving mental health services for American Indians include, of course, geographic isolation, major transportation barriers, and a very few service providers. Nationally there are only 150 American Indian psychologists to serve a population for whom cultural sensitivity and understanding are crucial to appropriate care.

What are the consequences of being under-served? More than one half of all American Indians who commit suicide have never been seen by a mental health professional. SAMHSA is proactively addressing these challenges from multiple directions. Right now we're working hard within the constructs of programs primarily designed by and for non-native persons. But we are working even harder to increase our understanding of native cultures, and to increase our level of response consistent with what we are learning.

SAMHSA has signed a contract with One Sky Center to develop a database of culturally appropriate prevention programs. In addition, we are part of a federal steering

committee led by the Indian Health Service, and with leadership provided by the Surgeon General's Office. We sit as a regular part of that steering committee. This committee is developing a national suicide prevention initiative for American Indians. Supporting this initiative is a new database system that will provide more and better information about suicide in native communities.

Prevention is especially, especially critical for American Indian communities in which cluster suicides are common. Two weeks ago, the Senate Subcommittee on Indian Affairs held a special hearing about suicides among American Indians. Twyla Rough Surface, a member of the Standing Rock Sioux described a series of suicides triggered by the accidental death of her young nephew. The day of the boy's funeral, one of his friends who had acted as a pallbearer committed suicide. The boy's best friend committed suicide two months later. The boy's sister committed suicide. The boy's mother attempted suicide. Following her attempt, the mother confided that her pain was so great she thought that only death could end it. No one involved ever spoke to a mental health professional or had grief counseling.

To prevent tragedies similar to those at the Red Lake and Standing Rock Reservations, SAMHSA is targeting new and ongoing suicide prevention efforts to American Indians. We've issued an emergency request for a proposal to provide

prevention technical assistance, planning, training and services in some of the most at-risk American Indian communities. We expect to award the contract to an American Indian-owned company with significant experience in this area.

In addition, when SAMHSA posted the request for applications for funding under the Garrett Lee Smith Memorial Act for Suicide Prevention Efforts, we actively promoted applications from tribal organizations. We hosted a conference call to provide an overview of the programs and to answer questions that a tribe might have, and to offer useful resources for developing an application. The Indian Health Service was a very helpful collaborator in helping us advertise this conference call. Just last week we hosted free teleconference training in how to decrease the stigma associated with mental illnesses among American Indian and Alaska Native communities.

Suicide is preventable. We can do a great deal to reduce suicide among American Indians if individuals at risk receive treatment and intervention. As with any mental illness, early identification and intervention is key.

In January, SAMHSA launched the National Suicide Prevention Lifeline at 1-800-273-TALK. The lifeline is part of the National Suicide Prevention Initiative. This collaborative effort led by SAMHSA incorporates the best

practices and research findings in suicide prevention and intervention. Along with the National Lifeline, a new website is being launched at www.suicidepreventionlifeline.org.

Part of our immediate response at Red Lake was to ensure that members of the tribe and the larger community would be aware of lifeline services. We made available for distribution more than 2,000 magnets that promote the toll-free number. I brought some of those today for you. In addition, we provided more than 2,000 wallet cards that describe the warning signs of suicide. Lifeline services also offer guidance and support to friends and family members who believe someone they know may be at risk.

We currently are working to improve lifeline services for American Indian communities. We're exploring ways to ensure adequate coverage across geographic regions, such as linking local crisis centers to the national lifeline. We've identified a American Indian communities as one of three target groups for a public education campaign about the lifeline. We will provide local organizations with information resources to publicize our suicide prevention services, as well as crisis intervention services that they provide.

SAMHSA is providing the Indian Health Service with an additional $200,000 to address suicide cluster response

and suicide prevention among Native American Indians and Alaska Natives. This funding will support programming and services contracts, technical assistance, and other related services.

One example is the development of a community suicide prevention tool kit. This tool kit will include information on suicide prevention, on education, on screening, on intervention, and on community mobilization.

The Administrator's policy at SAMHSA is to level the playing field by ensuring that tribal entities are eligible for all competitive grants for which states are eligible, unless there is a compelling reason to the contrary. In total, SAMHSA provides about $42 million to American Indians and Alaska Natives annually.

In 1999, Congress responded to school shootings at the Columbine High School in Colorado and in other states by launching a Safe Schools/Healthy Students Initiative. The Departments of Education, Health and Human Services and Justice collaboratively administer this program with SAMHSA as the lead within HHS. Two tribal sites were funded in the initial cohort of 54 grantees out of nearly 500 applications.

Comprehensive community mental health services for children and their families grant program, of course, also provides funding for direct services to improve systems of

care for children and adolescents with serious emotional disturbance and their families. Seven tribal organizations are among the current total of 63 grantees.

And, of course, we have Circles of Care, in which SAMHSA collaborates with the Indian Health Service and the National Institute of Mental Health in this grant program. The Circles of Care Program supports the implementation of mental health service models designed by American Indian and Alaska Native tribal and urban Indian communities. These models use a systems of care community-based approach to mental health and other supportive services for children with serious emotional disturbances and their families.

The substance abuse treatment targeted capacity expansion, or TCE grant program, continues to expand treatment opportunities and capacity in local communities that are experiencing serious emerging drug problems. Tribes and tribal organizations have received more than $31 million through direct and indirect grant awards during the past three years.

In addition, SAMHSA is working very hard to create a national strategic work force development plan. We're also initiating a project to examine behavioral health care education and to advance efforts to integrate mental health and primary care for racial and ethnic minorities, with particular attention to Native American communities.

Suicide is robbing American Indian communities of their most valuable resource, their children and their future. Suicide is the final hopeless act by individuals whose mental health needs have been unidentified, untreated, or inadequately addressed. To eliminate the high rate of suicide among American Indian teens, we first must address the comprehensive mental health and substance abuse needs of the American Indian community at large. We are in for the long haul. We are in for a broad-based approach.

The activities I've just described fit within our ongoing efforts, of course, to make sure that everyone in America has access to appropriate services, and, of course, that includes access to recovery and mental health transformation. SAMHSA currently is engaged in a national effort to create a mental health system that is consumer-driven and that is focused on recovery. We are moving toward that goal in part by working to improve cultural competency in programs and in providers, and to eliminate disparities in mental health care. These disparities are striking hardest at racial and ethnic minorities and those living in geographically under-served areas.

All Americans deserve equal access to the services and supports that can protect and promote sound mental health. Ensuring this access is the only way SAMHSA and our nation can fulfill the vision of a life in the community for

everyone.

I want to end with an unknown Inyut quote:

"I think over again my small adventures, my fears, those small ones that seemed so big for all the vital things I had to get and reach. And yet there is only one great thing, the only thing to live, to see the great day that dawns and the light that fills the world."

Thank you very much.

CHAIRPERSON CURIE: Thank you, Kathryn.

(Applause.)

CHAIRPERSON CURIE: I think it was difficult to listen to the account that Kathryn shared and not be moved by and overwhelmed by the tragedy at Red Lake, but I think more overwhelmingly, the daily plight that Kathryn described facing the American Indian and Alaska Native population in this country.

I'd like to open it up now for comments or questions from Council members. Ken.

MR. STARK: Do you know, Kathryn, is there any data that tries to get at how come the suicide rate in the Midwest is so much higher than in other tribes?

MS. POWER: I don't know, and I'm probably going to turn to my colleague from the Indian Health Service who's here with us today. My understanding is that the poverty level and the isolation are two major factors, Ken, in terms

of the fact that they're -- the isolation particularly. I mean, just think about the geographic location. The weather itself can be isolating.

MR. STARK: Right.

MS. POWER: The poverty levels, et cetera. So I know that in the literature those are two factors that certainly are contributory. I'm assuming that that is in fact what lends to the data that shows that there is such a higher rate in the Midwest, particularly because of the northern isolated regions and the level of poverty, combined with other factors. But those two seem to be the clearest in terms of the Midwest. I don't know whether --

MR. STARK: Before you respond, though, one more comment to that. I mean, that's what I was thinking, Kathryn.

MS. POWER: Right, I would assume.

MR. STARK: And so I was thinking, well, is that true, then, among other populations? Is the Midwest among all racial ethnic groups got a higher suicide rate --

MS. POWER: I don't know. But, you know --

MR. STARK: -- or is it unique to Indian country?

MS. POWER: I was prompted when we started talking about that in terms of Indian country to take a look at that. And so I'm going to go and take a look at that and see, you know, geographically. We obviously talk -- when we

talk at the state level about regional trends or regional kinds of factors, and I think that is a very good question and something we need to look at. So thank you.

Craig, if you wanted to add anything to that?

MR. CRAIG VANDERWAGON: George may want to comment, as well. (Speaks in Native American language.) For the health of the people. I think Kathryn's covered it pretty well. I think the isolation, poverty and racism plays more strongly in the Intermountain West generally than they do on either coast. The other things that are protective, I think, in one sense is that we terminated tribes in many of the West Coast states -- California, Oregon, Washington. For whatever reason, I think their recapture of who they are as Indian people was useful to them in terms of building internal dynamics that are supportive and protective.

I think the most successful Indian communities are those where the young people growing up know who they are as Indian people, and have the skills to compete with the dominant society. You see more of those successful kinds of communities in those environments than you see in the Upper Midwest, for whatever reason, I think. And that's something that needs to be studied by the Indian people themselves.

It's of interest, because some of those tribes have gaming money, and some don't. Twenty tribes in this

country generate 80 percent of the income from gaming. Those 20 tribes, obviously, have resources and are plowing those resources in. For most tribes, they do not make money on the gaming process. If they hire -- if they can put people to work, they've made major improvements in their community. But it's problematic.

The other thing is, I think, sovereignty as an issue has a different play on the coasts than it has in the Intermountain West. Remember, Indian Health Service, for instance, is not an entitlement program for individual Indians. It's built around a government-to-government relationship. The tribes on the coasts have been very aggressive about taking control of their own programs and exercising community policy in directing those programs. We see less of that in the Intermountain West and in the Upper Midwest than we see on the coasts. That's just an observation. I don't know that that necessarily contributes, but it's certainly suggestive.

The Administrator has been personally highly invested in this process. He's on a first-name basis with many of our tribal leaders, particularly up in your state. That's been critically important, because we're funded at about 50 percent per capita of what the Federal Employees Health Benefits package, for instance, provides in terms of per capita annual expenditures for care. Well, if you only

got 50 cents on the dollar, you really are working hard to try and make the most of those dollars. To have partners like Mr. Curie pitching in and supporting, and his leadership team taking it, embracing it, it makes a critically important difference. It also makes the move for tribes -- as was suggested here, if they're dealt with as states, then we're treating them like governments. That sets an expectation for them, as well, in terms of, hey, we've got to govern, and we've got to act like a responsible government. I think that has real positive improvements, as well.

I have some of my Indian colleagues here. George, do you want to modify or alter anything I've said?

MR. GEORGE REAL BIRD: Again, my name is George Real Bird. I am a member of the Crow Tribe in Montana. Like I come from that Midwest -- from what he was saying, you know, where suicide is higher. Crow Tribe, you know, we don't have as much substance abuse of what's going on. But in the Dakotas, where these incidents happened of suicides, they're almost a hundred miles, 200 miles from any major town or city. My tribe, we're next to the largest city in Montana, and so we have venues there. I can use a SAMHSA term, and it's "risk and protective factors." You know, we have bowling alleys, theaters. You know, we have sports venues to go to, whereas risk factors on those rural

reservations, it's -- the person you relate to within the world, if they are struck by a car accident or, you know, they die themselves, you know, the person you related to in the world is gone, so what's your point in this world? It's kind of a -- it's a tough thing to face, but that's one thing that's there.

CHAIRPERSON CURIE: Thank you.

MS. POWER: Thank you.

CHAIRPERSON CURIE: Other comments? Kathleen?

MS. SULLIVAN: I noticed when I was looking on the website that Indian tribes actually have to compete against states, especially in the case of suicide prevention grants. Is that true? I mean, shouldn't Native American tribes actually have their own -- you know, shouldn't they actually compete against each other for grants? Shouldn't they be designated only to compete against each other instead of competing against states?

CHAIRPERSON CURIE: I think you make a very interesting observation. The step of tribes being able to compete with states was to give them more opportunity, and actually recognize them as an entity that could apply for grants in those situations. Up until we instituted this policy over the past year and a half or so, tribes didn't even have an opportunity to compete. But what I'm hearing you say, Kathleen, are there other options we should think

about in which there's dollars just for tribes to compete for in light of the high need that's been described? That's what I'm hearing you say, and that's something that we need to evaluate.

MS. POWER: My sense is that, particularly because there's been so many hearings lately, Kathleen, that the senators and congresspersons from these affected states have really become very public about their concern. I think that's always a precursor or an indicator that there will be some step in that direction. In the meantime, of course, we're trying very hard to collectively make sure that not only are tribes competitive in terms of information, but also being able to try to get specialized supports out through other mechanisms, not just through Connecticut grants.

My sense is that there's going to continue to build congressional interest. I think we'll see some outcomes from that continued congressional interest over -- I think in the short-term.

CHAIRPERSON CURIE: Thank you.

Beverly.

MS. WATTS DAVIS: This is real quick. I wanted you to know, and Charlie and Kathleen, you need to hear this, as well. I can't remember what month it was because we travel so much, but I went to the White Bison Conference.

One of the things that they had as a town hall meeting about what -- and the regulations -- people came and they talked about that. Charlie, you and Kathryn should know, the feedback, it was so touching, because what they said was the fact that they felt so served. They felt like we were in partnership with them, and we were willing to go the distance. They really -- they were very -- it was such a touching moment -- and when they talked about their brief and all those things.

Sometimes in our -- we're sometimes up here, and you never really know if you're touching people or if you make a difference. But I wanted you to know, I met with them afterwards, and they were just so very, very -- "complimentary" is not even the word -- they were just so -- they really felt like partners with us, and that from there we could move forward. Sometimes you don't hear that, but you needed to know that, that that was the feedback given.

MS. POWER: Thank you. Well, I think one of the real struggles for us -- I think for all of us -- is to figure out how to be respectful and helpful at the same time. And it's a very fine line that we have to fully understand and more completely learn about the way to be respectful and helpful at the same time. It's very different in Indian country than it is with other cultures.

CHAIRPERSON CURIE: I would also highlight, that's

where the partnership with Indian Health Service has, I think, served us very well, letting them lead us in terms of what's the appropriate way. Our tendency is to just dive in sometimes. That, we learned, is not the most effective way. So again, to Craig Vanderwagon and to Chuck Grimm and their leadership team and folks, it's been a very invaluable partnership.

Ken.

MR. STARK: One of the other things I would recommend is adding to the partnership, if you haven't already, CMS folks, because the other financial opportunity, if you will, for tribes is to create their own programs and to tap into the Medicaid funding, either as federally qualified health centers or using the encounter rate dollars. Clearly, given the sovereignty, and given the agreements from the federal government going way back, there is a federal responsibility for health care services. So as much as tribes can tap into, with help from SAMHSA, facilitating how they can tap into those other federal fund sources that they may or may not be tapping into now.

CHAIRPERSON CURIE: That's very good.

MS. SULLIVAN: Aren't you chairing that plenary session? Isn't that the one that you're chairing?

MR. STARK: Well, it's called ugly money stuff.

MS. SULLIVAN: That's right.

CHAIRPERSON CURIE: Gwyn, did you have your hand up?

MS. DIETER: (No response.)

CHAIRPERSON CURIE: Oh, I do know -- I believe there's another individual who'd like to share. Please introduce yourself.

MR. ED BROWN SHIELD: I certainly will. Dr. Curie, and members of SAMHSA, my name is Ed Brown Shield. My affiliation is the Spirit Lake Tribe of North Dakota.

I think everything that was discussed here this morning is well-intended. But I think what we need to understand is we need to go a little bit further. There were 13 suicides at one time on Spirit Lake.

I'm going to give you an example, because it was so moving for me. I was asked to do a presentation to the elderly, which is a pretty strong organization on Spirit Lake. As I was driving up there, I said, geez, you know, I need to -- I want to talk about something that's going to be respectful, but yet I want to get the point across. So I started thinking about domestic stuff, domestic violence. Preferably, I want to talk about the sexual abuse. Immediately -- immediately -- a grandma came up to me and she said, you know, my grandson, we don't talk about stuff like that. And I said, you know, Grandma, no disrespect to you as an elder, but I need to talk about it, because it's

here, it's now, it's real, and it's happening.

Of those 13 suicides on Spirit Lake a while back, 12 of those individuals came from one family. The other one was -- come from a family that that individual was pretty prominent in our community.

When we talk about ways of approaching this, really it needs to be at a level where -- not the Band-Aid effect, because I was sitting at a hotel when they had this delegation of people coming in, and they were talking about, well, you know, we're going to do this and do that with suicides. Well, they were there, and the next day they were gone.

I need to tell you, you know, I grew up on Spirit Lake. Tragedy upon tragedy in my family, but I was able to deal with it. So when we talk about -- certain funding is the big thing. I'm very grateful for SAMHSA, because I applied for -- probably one of the first Native Americans to get a SAMHSA grant. I'm very thankful, because I utilized that unobligated money to start a 15-bed facility. I'm really proud to say that that is self-sustaining today.

But as a leader, I think a key ingredient is visionary. You need to be visionary. We need to see beyond our noses. But the other thing, and this is key, we need to be able to implement. That's what's going to make the difference. I went home in 1998 -- didn't want to go

home -- but I'm from Spirit Lake. I always thought, you know, my Native American people deserve the best. And I said, I want to implement and establish a quality program that's equivalent to anything in the State of North Dakota. Better yet, I want it to be equivalent to anything in the United States.

Overcoming local barriers, which we're going to encounter if we're going to look at some of these issues, that's why it's so critical to really look at, you know, yeah, depression -- I know that -- all of this stuff. But more important, people, they need to know that you're going in there with some real concern, and they need to -- and you're going to get 'em to be able to start trusting you. Because when you have leaders in tribal council who I think shouldn't be functioning in that capacity, our leaders, what do you got to look up to? They weren't roll models for me. I can openly tell 'em that, because education has done something for me that is pretty important. That's something nobody's every going to take away.

But I needed to tell you this because, during the course of that presentation, I looked out in the audience, and I told 'em -- I said, if I touch a soft spot with you today, it's not intentional. It's probably something you need to look at or address. In the course of my presentation, I heard somebody sniffling, and I just happened to

glance over, and it was a grandma. She was crying.

And so, you know, this is not something new. This goes way back. So it's pretty not only devastating, it's detrimental. In the course of my presentation, somebody else started crying. I looked over, and it was another grandma. You know, I was just waiting for that core group to say, you know, get the hell out of here, we don't want to listen to you. But you know what? They heard me out.

I built a quality program. I looked at -- they had a tribal program, IHS-funded. I went back to my home reservation in 1998 -- didn't want to go because I wanted to utilize my skill. I know today in my heart that it doesn't matter where I'm at, whether it's on a reservation, Washington, DC, or Bismarck, North Dakota, I am going to be an asset, because I got something to offer -- maybe a little bit of education.

But more importantly, them people trusted me. First thing, first comment came out, I was looking at state licensure. We really have a good working relationship with the mental health and substance abuse in the State of North Dakota. You can call any one of 'em and ask 'em about Ed Brown Shield. They'll tell you.

MS. POWER: That's great.

MR. BROWN SHIELD: So, you know, if we're going to do this, if you're thinking about developing a task force,

there's things that you have to look at within yourself. How are you going to deal with this? How can we be most beneficial to people that are struggling, people that have been hurting for generations?

And I wanted to share that because I'm no longer there. I'm on to a -- I always tell people I turned another chapter in my life. I'm in a graduate program at the University of North Dakota getting into a little bit of research.

That's another thing, you know, organizing is the big thing. I'm certainly a believer in community organizing, because if you can organize intervention teams and utilize your grass roots people, along with professionals, you're going to get some work done. And I really appreciate you guys lending me an ear, because I grew up in that stuff, and it's very difficult to overcome.

CHAIRPERSON CURIE: Thank you, Ed. Thank you so much. We appreciate your remarks

(Applause.)

CHAIRPERSON CURIE: I think we have time for one or two more questions from Council members on this issue, or comments. Gwyn, I saw you pulling your microphone forward.

MS. DIETER: I'm just sort of thinking out loud, because it's obvious that Kathryn is concerned and you're concerned. But the conversation -- I mean, I really

appreciate that Tom made his comments, because we're hearing about funding, we're hearing about money, we're hearing about -- I live in Colorado. We've lived near some Indian reservations which are not as isolated. How do you -- how through all this funding do you get some professional people who are committed to a long-term stay in these places to gather and work with people on the ground, the grass roots cooperation? I mean, to me, that's the issue.

It's terribly isolated if you've visited some of those places. I mean -- and the poverty -- but you need people who are willing. It's sort of like there are people -- legal services people who used to go out and commit to a three-year term on an Indian reservation down in New Mexico and stuff. We knew some people that did that. And only then with the people you build that trust, and then you build -- and then people can look at thinking in a new way if you can build that trust.

I mean, I just -- you can pour money -- there are a lot of situations in the past -- this situation is really not that new. Maybe it's just that we hear more about it. I mean, my feeling is that that's what I've heard ever since I've been in the West, and that's 34 years. It's terrible. And I think you're totally onto it. But what I would ask is that you focus on how to have this task force, have individuals who would -- professionals who are willing to

make a long-term commitment to live in these locations, and then gradually train and build support coalitions there.

CHAIRPERSON CURIE: I appreciate that. In fact, i know work force development's a major focus in the efforts right now, because you're exactly right, that we need to be thinking in terms of who will be the local resource that becomes part of the fabric of that tribe that can make the difference.

MS. POWER: We're actually trying to look at getting knowledgeable about how the Indian Health Service and HERSA and other federal agents have been able to look across some work force development programs, and then we think about how there's applicability to that for the behavioral health work force. But you really do have to have leaders like those we've just heard from who are willing --

CHAIRPERSON CURIE: Absolutely.

MS. POWER: -- to step into their communities and bring it to bear and bring it as -- and be community activists, and be the force within their own culture and within their own group. We have to think about, how do we help facilitate and support that in ways that I think would be empowering for those tribes? -- that there would be some investment longer term, and everybody didn't want to get out and leave, you know, but that there would be an investment

in terms of people staying.

MS. DIETER: And the leaders may be there right now.

MS. POWER: Right. Absolutely right.

CHAIRPERSON CURIE: We need to foster that.

MS. DIETER: They may become that with some knowledge.

MS. POWER: That's right.

CHAIRPERSON CURIE: Thank you, Gwyn.

A quick check of the lay of the land in wrapping up, I see Ken, Tom. Do you want to make a comment? And I see Craig. Those three lightning round comments here, and then we'll move to public comment.

MR. STARK: I was going to be fairly quick. And, Ed, I really appreciate what you stated. It's very challenging for somebody from Indian country to go into a tribe and talk about the sexual abuse, or talk about the tribal chair who got three DUIs, and, you know, bring that issue up and not get run out of town, if you will. We all know that until those issues get resolved, it's going to be really, really difficult for kids and families to have change within their community.

So we really do need to identify leaders within each of the tribes and across the country who are willing to step up and step out. And we need to support them. I

really appreciate what you said.

CHAIRPERSON CURIE: Craig, and then I'll let Tom have the last word.

MR. VANDERWAGON: Just to reply to your comments, both of them, 75 percent of our employees at Indian Health Service now are Indian people. When I started 25 years ago, it was more like 25 percent. So we've made major improvements in developing capacity at the community level to do for themselves. That's really our public health mission. It's not so much about delivering medical care as it is about developing that capacity.

The reason we're just getting to it in some ways is because, first, we had to keep children from dying unnecessarily in infancy. And now our infant mortality is actually better than the U.S. general population in most places, the exception being that Upper Midwest.

So we've made improvements on that front. Now maybe we're getting to the core of where we got to go.

I think your comment, Ken, about the fact that we are developing positive leadership is critically important. That's where Charlie's first-name basis with Darrell Hill Air (ph), for instance, up at Wamee (ph) becomes important. You as a group, I think to the degree that you know some of these Indian leaders, they have common purpose with you.

Again, those that have gaming capability are

becoming more engaged in the outside world, and I think can be a useful adjunct to this Advisory Committee in terms of people that you can work with in an effective way to the degree you're interested in Indian communities. Ultimately it goes to Charlie's comment. When you started, Charlie, I was really -- as Charlie knows, I spent six months in Iraq as the Primary Care and Public Health Director there for the Ministry of Health. The lessons that we're learning from Indian country have so much applicability in moving forward with the President's agenda around health diplomacy as a tool in developing democracy. These issues -- depression is the leading diagnosis on a worldwide basis, particularly among women. So what we learned from our Indian experience here and cross-cultural realities has real significance on a broad scale, first, because we owe it to the Indian people to give them the best we can. But secondly, because what we all learn collectively allows us to do a better job elsewhere, as well. That's my comment.

CHAIRPERSON CURIE: Thank you very much, Craig.

Tom.

MR. KIRK: I think the points that people made, I don't want to repeat them. That's fine.

CHAIRPERSON CURIE: All right. Thank you.

Kathryn, thank you so much.

(Applause.)

CHAIRPERSON CURIE: We had no one sign up for public comment. The great news is we've had public comment throughout this report. I would -- is there anyone from the public who would like to make a comment before we move on? Yes?

UNIDENTIFIED MALE SPEAKER: I did send in a fax earlier saying I would like to speak.

CHAIRPERSON CURIE: Okay. Thank you.

UNIDENTIFIED MALE SPEAKER: I have some handouts here that I'd like to pass around.

I'm with the National Association on Alcohol, Drugs and Disability, and Faces and Voices of Recovery. I understand I'm the only thing standing between you and lunch, so I'll make this pretty quick.

Welcome to California. As an East-Coaster originally myself, I can attest to the value of having a West Coast perspective, which you'll all get over the next couple of days. I would encourage you to come to Northern California at some point in the future, though, because we have even better things up there to offer you.

MS. SULLIVAN: Boo.

UNIDENTIFIED MALE SPEAKER: In fact, during a research visit to Napa Valley for the Substance Abuse and Mental Health Services Advisory Council might be a good thing at some point.

I'm here on behalf of 51 million Americans with disabilities, who have less access to services and more alcohol and drug problems than the general population. I'm here to mention that we are still waiting for SAMHSA, and specifically the two substance abuse centers, to come up with some designated and categorical projects and funding and services for people with disabilities.

We've had many conversations with Dr. Farr (ph), and some conversations with Mr. Curie. The people that you in your materials talk about not being able to get into treatment, or if they're able to get into treatment, not able to be retained in treatment, many of them are people with disabilities. If we could see some specific categorical programs coming out of SAMHSA for people with disabilities, we would certainly appreciate it, specifically, the target capacity expansion program with a disability spin.

I'm talking about physical, sensory, developmental and cognitive disabilities. It's 15 years since the Americans with Disabilities Act was passed. It's the 15th anniversary. And still many alcohol and drug programs are not accessible. We get calls almost every week from people who are not able to be accepted into treatment because the program doesn't have a ramp, or doesn't have a TDD, or doesn't have training in disability.

So the ADA is very important to people with disabilities who want to access substance abuse services. But the second and last thing I'd like to say is that the ADA is very important to people in recovery, as well, as we know. There is no such thing as the Americans with Addictions Act. It is the Americans with Disabilities Act that does provide the protections against discrimination, which is the flipside of stigma, for people in recovery. Dr. Clark knows this really well.

We have been trying to alert the alcohol and drug fields to a variety of court challenges that have eroded the disability status of people in recovery, as well as people with other disabilities. The last time I was here to talk to you was two years ago. The case was Hernandez, and it was in front of the Supreme Court, and one of the handouts that you have is about that case. There are other cases that are coming up right now. There's a case, a class action, against UPS, there is a case against New York State Corrections, where people in recovery from substance abuse are treated differently because of their recovery status than other people.

As the disability community fashions a legislative response to this, often referred to as the ADA-II, it's really important for the alcohol and drug field and the mental health field to be connected to that initiative. And

that's really not happening. And that's the other handout that you have in front of you about these erosions and the need for the alcohol and drug field to become better educated about the ADA, and how the ADA really does fight stigma by fighting discrimination.

I'd really encourage SAMHSA and the centers -- and Dr. Clark and I have had a number of conversations about this, and I know he's very much on board with this. We have got to be at that table. We were not at the table when the ADA was originally crafted, and we've got to be at the ADA-II table.

Thank you very much.

CHAIRPERSON CURIE: Thank you, John. Thank you.

My understanding is that the food is ready and on the table. So would you explain -- do we just go over across the hall?

MS. VAUGHN: Just go over to the bar area, and that's where you're going to enjoy your lunch. And then after that --

CHAIRPERSON CURIE: Please tell us about where people are meeting and what are the logistics for that.

MS. VAUGHN: Okay. After your lunch, then you'll meet in the lobby. There'll be a van to transport you to Scripps Hospital for your site visit. You should be in the lobby at 12:15 -- I mean, 1:15. The van will leave at 1:30.

CHAIRPERSON CURIE: All right.

UNIDENTIFIED MALE SPEAKER: Are we closing up this room, or can we leave our stuff in this room?

MS. VAUGHN: Okay. You can leave your materials in the room. We're going to adjourn the meeting. If you want us to transport your materials, to send them to you, you can either take the materials with you, or just leave them there, and we will mail the materials to you.

CHAIRPERSON CURIE: Is there someone who would move to adjourn?

MS. SULLIVAN: Move to adjourn.

CHAIRPERSON CURIE: Kathleen, and then --

MR. AIONA: Second.

CHAIRPERSON CURIE: -- Duke seconds it.

Meeting's adjourned. Thank you.

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(The meeting adjourned at 12:30 p.m.)

CERTIFICATE

I, Michael J. Williamson, certify, under penalty of perjury, that the foregoing is a verbatim transcription prepared from the electronic sound recording produced at the proceedings in the above-entitled matter, and is a true and accurate transcript of said proceedings to the best of my

ability and belief.

_____ _____

Transcriber Date